Strategic Planning for Workplace Alcohol and Drug Abuse Programs

Second Edition

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Preface

This document was prepared for the Division of Applied Research, National Institute on Drug Abuse (NIDA) by Thomas E. Backer, Ph.D., Human Interaction Research Institute, Los Angeles, CA. The first edition was published in 1987.

Extensive assistance in editing and revising this volume was provided by Charles E. Williams, M.H.S., CEAP, of the Center for Substance Abuse Prevention (CSAP), Division of Community Prevention and Training, Workplace Community Prevention Branch. Charles E. Williams served as the CSAP and NIDA Project Officer for this revised edition.

This second edition of *Strategic Planning for Workplace Alcohol and Other Drug Abuse Programs* provides much new information and additional resources that have been developed since the first edition was drafted in 1986. While the table of contents may appear similar, many important changes have occurred and significant growth has taken place. A wealth of new knowledge has been gained from many innovative workplace-related programs that have been developed over the past 8 years. That knowledge has been incorporated throughout this second edition.

For example, the use of "incremental change approaches" has been added to the overall strategic planning concept. In addition, sections on guidelines for small employers, health insurance and managed health care, quality of treatment, relapse, HIV/AIDS, and alcohol and other drug abuse have been added. The examples for strategic planning and for incremental change approaches programs, workplace resources on alcohol and drugs, and the bibliography have all been updated. In summary, a wealth of new information has been incorporated to make this a current and comprehensive working document for those who want to plan, implement, and improve workplace programs for alcohol and drug abuse.

Foreword

Substance abuse impinges on all aspects of American life—it threatens families, schools, communities, and the integrity of the workplace. Much progress has been made to prevent and treat the problems caused by substance abuse. Still, American businesses suffer billions of dollars in losses attributable to alcohol and drug abuse each year. They cannot afford such losses in the context of the rising competitive global marketplace. In addition, employed Americans suffer immeasurable human losses—both mental and physical—because of their abuse of alcohol and drugs. The public health consequences are further heightened by the connection between illicit drug use and the spread of the human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS).

How widespread is the problem? The 1993 National Household Survey on Drug Abuse conducted by the Substance Abuse and Mental Health Services Administration reported that 7.35 million persons age 18 and older had used an illicit drug within the past month. In addition, 7.67 million employed adults were reported to be heavy alcohol users (five drinks or more, five or more times in the last 30 days). Combine the problems of illicit drug use with the abuse of alcohol and the misuse of prescription and over-the-counter drugs, and it becomes obvious that all sectors of our society, including the workplace, must be a part of the solution.

Employers cannot afford to ignore a problem that affects so many of their workers and impacts so directly on their bottom line. They are responsible for providing and maintaining a healthy and safe workplace for all employees, for ensuring the best product or service achievable, and for protecting shareholders and the public from losses caused by substance abuse. How can employers carry out these responsibilities in view of the impact of alcohol and drugs in the workplace? Where should they start? Important first steps are realizing that they can take effective action, making a commitment to do so, and developing a plan to get started.

The Center for Substance Abuse Prevention (CSAP) has been working to help communities and employers develop comprehensive alcohol- and drug-free workplace programs that stress developing a clearly written policy, providing supervisory training and employee education, developing employee assistance programs to help substance-abusing employees and their families, and using appropriate drug testing as part of a comprehensive workplace program. CSAP has also helped businesses participate in community prevention efforts.

This second edition of *Strategic Planning for Workplace Alcohol and Drug Abuse Programs* provides a written guide to help businesses through the complex process of planning and organizing alcohol and drug abuse programs. It will help decisionmakers understand the complexity of our Nation's alcohol and drug problems, and will enable them to make informed choices and identify additional resources to make their jobs easier. I am confident that the ongoing efforts of business and labor to address the problems of substance abuse in the workplace will save countless careers and reputations, improve productivity and profits, and help promote and preserve the health and well-being of American families.

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Contents

1. The Challenge

What Employers Already Know

The great American actress Helen Hayes once said: "It's what you learn after you know it all that really counts." Today's employers already know a lot about alcohol and drug abuse and the challenge it presents to their organizations and to society. Most employers know that

- A significant number of U.S. workers use alcohol or drugs.
- Substance abuse endangers the health and safety of these workers, their coworkers, and often the public as well.
- Workplace alcohol and drug abuse affects productivity and profits.
- Substance abuse also affects workers' personal lives, their families, and the community.
- Many solutions are now being offered for the problem of workplace substance abuse. Some examples are workplace policies on alcohol and drugs, supervisory education, worker education, Employee Assistance Programs (EAPs), and drug testing programs. These solutions vary in their cost and effectiveness.

By 1987, the issue of alcohol and drugs in the workplace had risen to a new level of public awareness, along with an increased public attention to the problems of alcohol and drugs in general. Speeches by the President of the United States, coverage on network television and in national magazines, and widespread attention in the business press were just a few signs of the importance that substance abuse in the workplace had attained.

Responses included Federal, State, and local legislation; many individual employer, labor union, and community initiatives; more empirical research than had ever been done before; and a considerable amount of public debate. Drug testing became a growth industry, and EAPs proliferated. Many employers began to look at what worker alcohol and drug abuse was costing them in terms of lost productivity, accidents, and public image.

In the 1990's, employers are faced with the reality that simple, one-step, and low-cost solutions to the workplace substance abuse problem are generally not very effective. Incremental change based on effective planning and identification of useful, cost-effective resources is essential.

During the past few years, the mass media, the Federal Government, employer groups, labor organizations, and management consultants are among those who have helped employers learn about workplace substance abuse. Most employers now know there is a

problem that needs a response. In responding to these challenges, employers must make at least three commitments: leadership, resources, and strategic planning.

Meeting the Challenge: Three Commitments

This publication is designed to guide employers in developing or enhancing workplace alcohol and drug abuse programs. It assumes that employers, in conjunction with workers at all levels and with outside experts or resource organizations, can develop an effective program. A workplace substance abuse program is not like a new copying machine or other commodity that can simply be bought and plugged in. To be effective, such a program needs to be treated as a major organizational initiative.

To undertake the significant organizational change most programs require, employers must make three commitments:

1. *Leadership commitment*—showing enthusiastic support from top management for the workplace substance abuse program, typically expressed in a written policy about alcohol and drugs in the workplace and the nature of company responses to substance abuse.

2. *Resource commitment*—providing the needed personnel and financial resources within the organization, as well as knowledge of the required community resources for delivering alcohol and drug abuse prevention and treatment services.

3. *Strategic planning commitment*—adopting a well-designed strategic plan that develops an effective workplace substance abuse program and appropriately locates it within the organization.

Leadership support is provided by the overall policies, philosophies, and models of private sector employers (including coordinated efforts of such groups as the Business Roundtable, U.S. Chamber of Commerce, and major business enterprises across the country), their counterparts in the public sector (government agencies, nonprofit organizations, etc.), and by the Center for Substance Abuse Prevention (CSAP). CSAP has developed a number of products and services that can help employers develop or enhance their alcohol- and drug-free workplace activities.

An array of *resources* is presented in this publication, including materials from CSAP, reports on research from CSAP and other agencies, and many articles and books from both the business and academic sectors. In addition, multimedia training programs are described, and organizations that can help employers locate other information or assistance are identified.

The *Strategic Planning Model for Workplace Alcohol and Drug Abuse Programs* is presented in some detail. This model is designed principally to help medium-size and larger employers design, evaluate, or enhance the programs needed in their workplaces. In chapter 7, some special resources and approaches designed for small employers are also provided.

The Strategic Planning Model, which is the heart of this publication, is based on management approaches already common in both the private and public sectors. The suggested application of this model relies on another management concept—*incremental change*. This concept encourages organizational decisionmakers to have an overall plan or vision for change in place as part of their strategic plan. However, it also acknowledges the reality of tight resources and competing priorities (as well as the difficulties of making

change happen in any organizational setting—for example, the problem of staff resistance to change) by encouraging adoption of the overall plan one or two steps at a time.

Over a period of one or several years, the component parts of a strategically planned workplace substance abuse program can be initiated in this fashion. Such an incremental approach can increase the likelihood of success because the employer can undertake later efforts more efficiently by taking advantage of the experience gained while implementing the early components.

Another advantage of the incremental approach to change is that employer experience with workplace alcohol and drug abuse programs over the last several years makes it clear that most worksites require multiple program components. EAPs, drug testing, or other elements of a response implemented in isolation often do not work very well. If resources are limited, incremental change allows a complex (and perhaps expensive) program to be initiated in stages.

All solutions have to be carefully evaluated to determine their potential for enduring impact. Alcohol and drug abuse treatment programs vary widely in quality, for example, and even the best programs can be compromised unless good aftercare is also provided (see discussion of the problem of recidivism in chapter 6). Management training by consultants or audiovisual materials can be little more than quick-fix solutions, unless they are chosen to fit an overall workplace program. Employers must realize that there are no easy answers to the problem of alcohol and drug abuse in the workplace.

Strategic planning of incremental change and dedication of multiple resources are necessary for an effective response to the challenge of alcohol and drugs in the workplace, because of the complexity of the substance abuse problem itself. Addictive behavior is one of the most complex behaviors to change or prevent; effective programs must reflect that complexity. This is perhaps the most important message of the late 1980's as far as alcohol and drugs in the workplace are concerned.

A strategy of incremental change is an alternative to the quick-fix approach in an environment with tight resources but considerable need. Such an approach maintains an overall vision of what the organization wants to accomplish with its alcohol- and drug-free workplace program. In effect, incremental change is a commitment to do an important job well, even if implementation has to come in steps.

In chapter 3, the strategic planning model is described, with details about the incremental approach to organizational change, based on discussions of this concept in the management literature. In chapter 5, authentic examples are given of how each of the five components in a workplace substance abuse program model has been implemented.

Although alcohol problems have been a major concern to industry for well over 20 years, until the 1970's abuse of drugs such as cocaine and marijuana drew much less attention. Even as managers began to observe the effects of the epidemic of alcohol and drug abuse, little systematic planning and action were undertaken. Employers were slow to respond because they did not realize how widespread the problem was, and they had few ideas about how to combat it. Managers were not sure how to recognize the signs of substance abuse and were often afraid to confront workers who appeared to be under the influence of alcohol or drugs. As many young people who grew up in the drug-tolerant 1960's came into the labor force, prevailing attitudes about alcohol and drug abuse changed. Employers found that taking action was not easy and feared the bad publicity and possible legal complications that could come from a crackdown.

By the mid-1980's, this situation had changed dramatically. Policies regarding alcohol and drug abuse had become common in workplaces of all sizes. EAPs, one of the main vehicles for intervening with alcohol and drug abusers in the workplace, had begun to pay more attention to substance abuse.

The problem is clear and it is serious, whether expressed in human or economic terms. It is also clear that the problem will not go away without active interventions. The key questions, however, are what interventions to use, and how to effectively implement them.

Ways to Use This Publication

Four major uses are anticipated for the material that follows:

1. *Evaluating an existing program* to determine whether it addresses the special problems that workplace substance abuse represents—the facts that most drugs in the workplace are illicit; that misuse of prescription drugs can affect job performance; and that some drugs like crack cocaine are more intensely and rapidly addictive than alcohol. Many workplace programs may already be doing much that is suggested here; however, a review using the strategic planning structure should identify areas for possible improvement.

2. *Enhancing an existing workplace program* to provide more focused, effective attention to worker abuse of alcohol and drugs. Very often, this effort means enhancing an EAP that already includes services to workers with alcohol and drug abuse problems by redefining the substance abuse policy, adding new services, improving health benefits, providing supervisory training, and offering employee prevention and education activities, for example.

3. *Extending an employer's activities* into providing alcohol and drug abuse and related services for workers, using the continuing concern about substance abuse to involve labor, management, and the community. This action may be especially helpful for small employers who have not recognized they might have workers with problems, or who thought they could not afford their own workplace alcohol and drug abuse program. (Chapter 7 identifies some helpful strategies for small employers.)

4. *Complying with legal mandates from the Federal, State, or local levels.* Since the passage of the 1988 Drug-Free Workplace Act and other Federal, State, and local legislation, employers have needed to be increasingly responsive to legal directives. Litigation and court decisions are also factors to consider.

For many employers, the high level of visibility and attention to alcohol and drug abuse represents an opportunity for an "organizational passage"—that is, a chance to move to a new level of maturity in effectively handling human resources. These responses take place in a highly complicated environment involving health care benefits (and a need to contain health care costs), health promotion activities, and an employer's entire human resource development strategy and policy on social responsibility.

Workplace Alcohol and Drug Abuse: The Special Context

Part of the complexity employers must address in developing or enhancing a workplace substance abuse program is the special nature of drugs of abuse. Some of the complexities that should be considered when viewing the problem of employee abuse of alcohol and drugs include the following.

1. *Use of most drugs, except those prescribed for medical purposes, is illegal.* Employees using drugs illegally are subject to arrest and imprisonment. Moreover, drug-abusing workers often buy their illicit drugs in the workplace, introducing further illegal activity. This situation can create problems of safety and security, and can increase the likelihood of other criminal behavior in the workplace (e.g., stealing in order to buy alcohol or drugs). In worst-case scenarios, the whole social structure of the workplace can be jeopardized; for example, a medical director fighting the abuse of alcohol and drugs on the job site may receive death threats, or workers may be assaulted and robbed by other substance-abusing employees.

2. *The shield of medical necessity often obstructs the ability to identify and assist workers with substance abuse problems.* Prescription drugs are widely abused, but workers may be able to hide behind the claim, "My doctor told me to take these pills."

3. *The toxicity of some drugs (e.g., crack cocaine, ice/methamphetamine, and many "designer drugs") is much greater than that of alcohol in the doses generally taken, and these drugs can lead to much more rapid and severe physical and psychological consequences.* Substance abuse specialists note that it often takes 20 years for severe physical side effects to emerge from abusing alcohol, as compared with 6 to 12 *months* for crack cocaine. Deaths from alcohol overdoses, while not unheard of, are rare. (However, deaths from long-term complications of alcoholism are more common, and the social, safety, and health costs of alcoholism are, according to most estimates, higher than those for use of illicit drugs.)

4. *Some drugs are often difficult to detect.* Excessive use of alcohol on the job leads to drunken behavior, which is usually hard to conceal, but workers on drugs such as cocaine—even heavy users—often can maintain an appearance of normality. Detection is made much more difficult by the worker's active efforts to conceal and deny a problem and by the frequent complicity of coworkers in shielding the person with the problem. Drugs such as marijuana may exert subtle, but significant, effects on perceptual-motor performance. Workers using cocaine may seem energized and creative, but when evaluated more carefully, their ideas are often thin and their judgments weak.

5. *The traditional focus of EAPs on alcohol, rather than on drugs such as cocaine, is still evident in some workplaces.* Many early EAPs were operated by recovering alcoholics, and in some cases services may still be oriented in this direction. However, even the most expressly alcohol-oriented program today serves workers abusing drugs as well. Some EAP staff have not received specific professional training about issues pertaining to drug abuse, and this may limit their effectiveness. Similarly, some supervisors may not relate performance problems to abuse of drugs, since the signs and symptoms can be somewhat different from those of alcohol abuse. Training programs can help in this regard.

Key Issues Relating to Alcohol and Drug Abuse in the Workplace

Following is a brief overview of some of the most important issues facing management and labor in preventing alcohol and drug abuse in the workplace. Page references identify where in this publication each of these issues is discussed.

1. Organizational policy on substance abuse—What kind of written policy should an employer have, and how should it be developed and implemented? (pp. 21, 25, and 41)

2. Supervisor training and employee education regarding alcohol and drug abuse—What kinds of educational goals are appropriate for supervisors and for employees, and how can training be conducted in a cost-effective, nonintrusive way? (p. 22)

3. Health care cost containment as it relates to worker substance abuse (the costs of EAPs and of alcohol and drug abuse treatment, as well as the costs of other health care services precipitated by substance abuse)—How can employers help hold the line against increasing health insurance and workers' compensation costs that are rising at 10 percent to 20 percent per year? (p. 73)

4. Identifying illicit drug users—Should employers have a drug testing component to identify applicants or employees who have used illicit drugs? (pp. 24 and 46)

5. Insurance coverage for alcohol and drug treatment services—What services most likely to help workers deal with a substance abuse problem should be covered (e.g., outpatient and long-term followup aimed at reducing recidivism)? (p. 73)

6. Workplace security—What efforts should be made to halt drug trafficking or possession of illicit drugs in the workplace? (p. 50)

7. Safety of workers and the public—How can employers assure both workers and the general public that they will not be put at risk because of the behavior of employees using alcohol or drugs? (p. 5)

8. Impact of alcohol and drug abuse on worker motivation, decisionmaking, and creativity—How can this threat to product and service quality and productivity best be dealt with? (p. 11)

9. Availability of accurate and timely information on workplace substance abuse and needed training and consulting services—What do employers need to provide to their supervisors and workers, and what steps do they need to take to find what supervisors and workers need? (p. 14)

10. Workplace substance abuse programs as a "management fad" and a quick-fix solution to serious, ongoing problems—How can management avoid taking the quick-fix trail, which usually leads to ineffective programming that may waste human and financial resources? (pp. 2, 17, 25, and 31)

11. Strategic planning for effective workplace alcohol and drug abuse programs—How can employers use strategic planning to develop or enhance their own programs? (chapters 3, 4, and 5)

12. Integration of workplace substance abuse programs with other health care/human service issues—How can these programs be blended with health promotion, AIDS

in the workplace education, and other important workplace concerns such as safety and security? (p. 37)

13. Legal liability of employers regarding drug testing, EAPs, and other activities (both those employers who have these program components and those who do not)—What are the liability issues and how can employers minimize their own liability? (p. 49)

14. Program effectiveness (both of workplace alcohol and drug abuse programs and of community treatment programs for employee referral)—How can effectiveness be evaluated and how can the results be used to improve the ongoing program? (p. 54)

The Extent and Impact of Workplace Alcohol and Drug Abuse

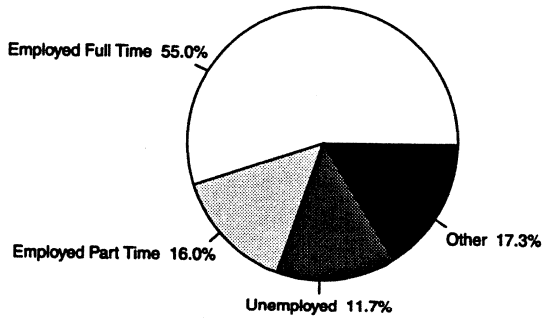
Recent polls of both the public and employers, as well as a substantial amount of social science research, confirm that alcohol and drug abuse among employed persons is one of the Nation's most important problems. With alcohol and drug abuse costing employers billions of dollars in lost productivity and accidents, and with perhaps 7 percent of workers having a serious addiction problem, alcohol and drugs in the workplace are a significant management and economic concern, as well as a human one.

Extent of Illicit Drug Abuse in the Workplace

Although recent surveys sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA) have shown a consistent decline in Americans' use of illicit drugs since the 1970's, recent studies such as the 1993 National Household Survey show a continuing problem of drug abuse in the workplace.

- The majority (71 percent) of illicit drug users in the United States are employed full time (55 percent) or part time (16 percent) (see figure 1).
- Among 18- to 25-year-old full-time employed Americans, 14.3 percent used an illicit drug in the past month, and 26.6 percent used an illicit drug in the past year. This included significant marijuana and cocaine use (see figure 2); 11 percent of survey respondents had used marijuana and 1.5 percent had used cocaine in the previous month.

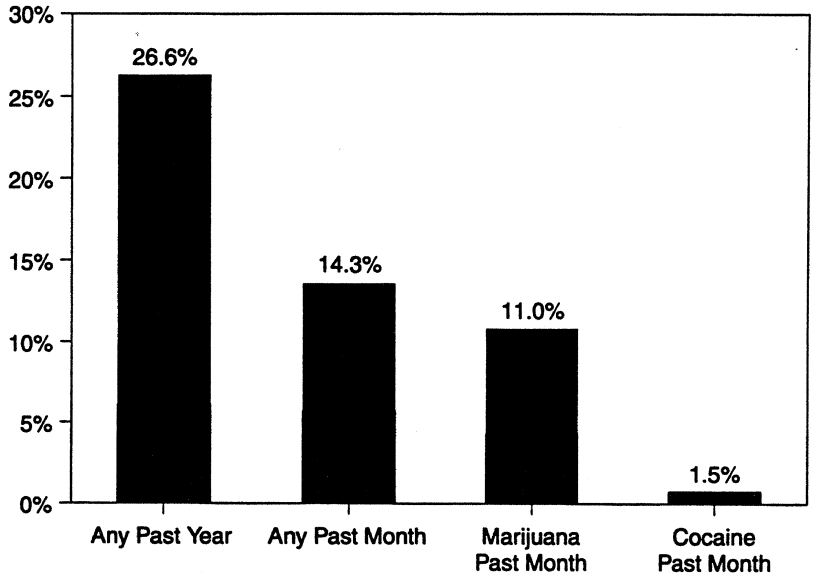
Figure 1. Past year drug users age 18 and older (any illicit drug) by employment status—1993



Note: "Other" includes retired, disabled, homemaker, or student.
Source: SAMHSA, National Household Survey on Drug Abuse, 1993.

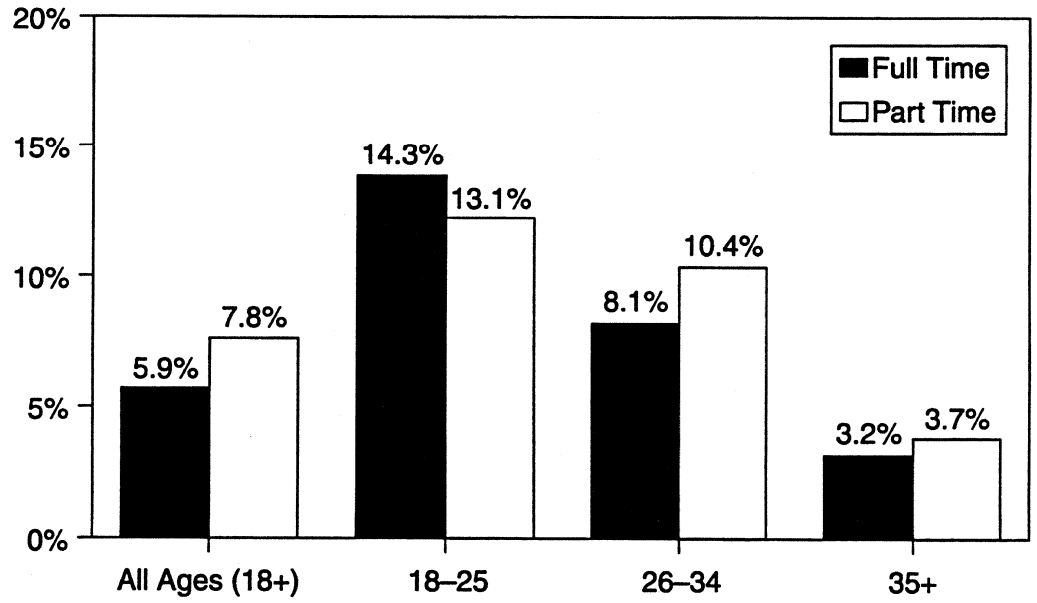
- Illicit drug use is greatest among the youngest component of the work force, ages 18 to 25 (see figure 3).
- Illicit drug use among 18- to 49-year-olds is greatest among employees in eating and drinking places (see figure 4).
- In 1993 8.4 percent of workers and job applicants tested positive for drugs, which was down from 18.1 percent in 1987 (see figure 5).

Figure 2. Illicit drug use among 18- to 25-year-old full-time employed Americans



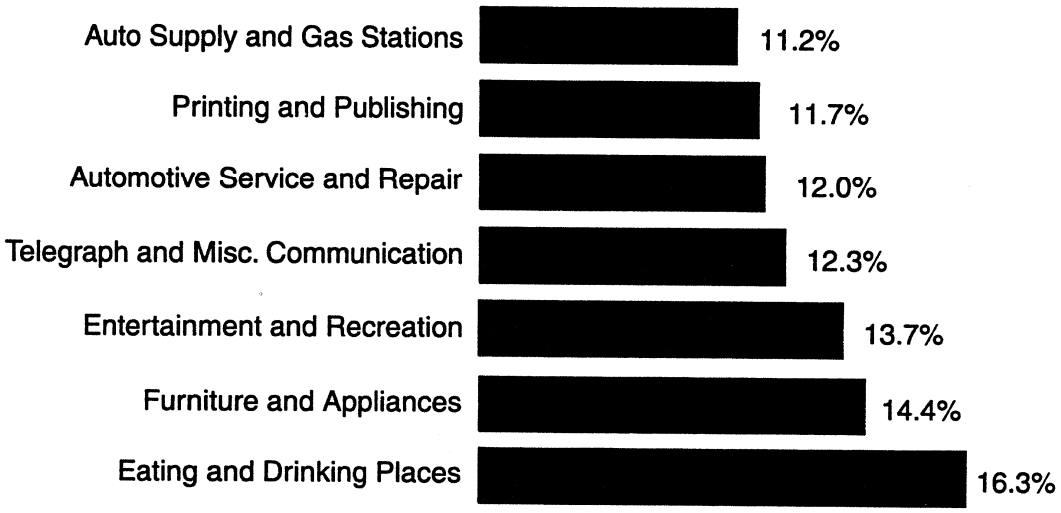
Source: SAMHSA, National Household Survey on Drug Abuse, 1993.

Figure 3. Drug use among employed persons in the past month—by age and employment status



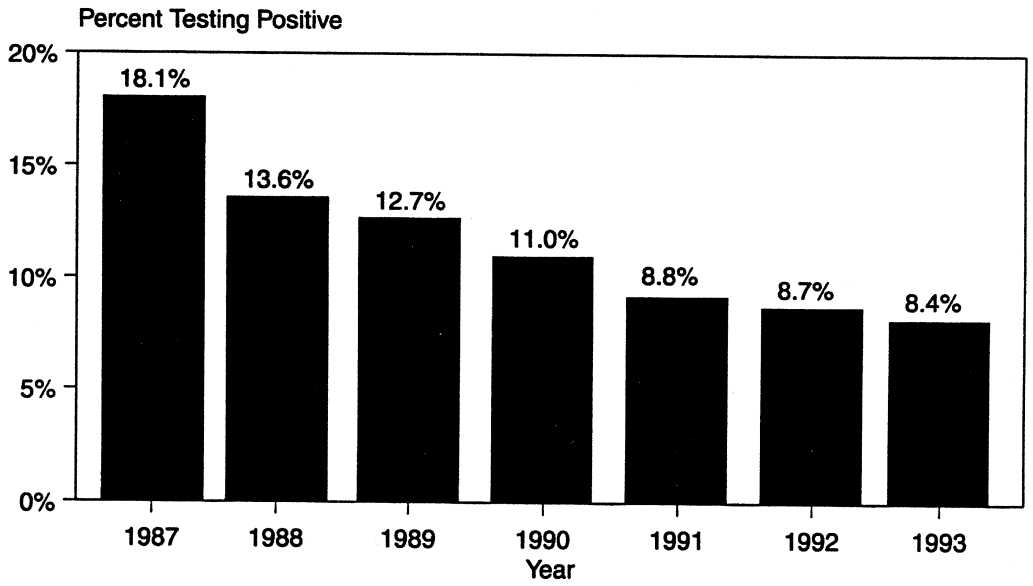
Source: SAMHSA, National Household Survey on Drug Abuse, 1993.

Figure 4. Current (past month) drug use among 18- to 49-year-olds—full-time employed, by industry



Source: SAMHSA, National Household Surveys on Drug Abuse, 1991–1993.

Figure 5. Drug use in the workplace—nonfederally regulated workers and applicants



Source: SmithKline Beecham Clinical Laboratories Drug Testing Index, 1994.

Illicit drug use can have dramatic impact on worker and public safety, as well as on corporate profits and/or workplace operating expenses. Three recent examples follow:

- In 1987, a Conrail worker who later tested positive for marijuana was at the controls of a train that collided with another; 16 people died and 74 were injured in this accident.
- Twenty employees, including two supervisors, were terminated at an airplane parts manufacturing plant for using marijuana and cocaine during work hours and break times.
- A computer operator affected by marijuana loaded the wrong computer tape into an airline's computer reservations system, with a resulting loss of $18 million.

National estimates of illicit drug use in various workplace populations have been the subject of considerable recent research. Several presentations from the 1989 Drugs in the Workplace Conference in Washington, DC (Gust & Walsh 1989), utilized survey data from national samples to confirm that significant illicit drug use is occurring among employed people. The presentations also provided detailed descriptions of where and how illicit drug use is occurring within the overall work force.

In a 1989 study by Royer Cook, 18 percent of a group of employed adults reported using marijuana in the year previous to the survey, and 11 percent said they were currently using it. Six percent had used cocaine in the previous year, and 2 percent were current users. Both marijuana and cocaine use were found to be more common for workers under the age of 35. With respect to occupational category, workers in the skilled trades (16 percent), sales and manufacturing (15 percent), and owners of businesses and farms (13 percent) were found to be the most frequent users of marijuana. Laborers (5 percent) and service workers (4 percent) were the most frequent users of cocaine.

These findings are consistent with data from a longitudinal study published in 1987 by James Schreier, who studied perceptions of workplace substance abuse in a moderate-sized group of work sites in 1971, 1976, 1981, and 1986. Schreier's 1986 data indicated that 95 percent of the responding companies had confronted a substance abuse problem in the workplace. This compared with 82 percent in 1981 and only 36 percent when the study was initiated in 1971.

In 1988, Michael Newcomb conducted a longitudinal study of the disruptive abuse of alcohol and other drugs by young adults (aged 19 to 24). (In Newcomb's terminology, "disruptive" pertains to alcohol and drug abuse in inappropriate settings, primarily work or school.) While the prevalence of alcohol and drug abuse in his sample of young adults was high, only a small percentage abused alcohol or drugs at work or school on a regular basis. Of those who regularly engaged in disruptive substance abuse, beer was the most common substance, followed by marijuana, then cocaine. Newcomb found that 31 percent of young adults reported abusing a drug or alcohol in an inappropriate setting from one to five times within the past 6 months.

Even though young adult men and women had equal rates of general substance abuse in Newcomb's study, men were substantially more likely to abuse alcohol and drugs at work or school. African Americans were more likely to use marijuana at work, while Whites were more likely to use cocaine. Asians were least likely to engage in disruptive substance abuse, and Hispanics were in the moderate range on this variable.

Impact: Work Performance

Controlled research on the effects of alcohol and drug abuse on simulated job performance is generally lacking; also lacking are field studies of relationships between substance abuse and real job performance indicators such as absenteeism, accidents and injuries, job turnover, health care costs, supervisory ratings, and other measures of productivity.

Early research on the impact of employee alcohol and drug abuse on organizational behavior tended to be based on data collected from surveys, questionnaires, or interviews. While such methods can result in useful information, there are some inherent limitations in these methods. One difficulty stems from problems generating accurate data based on self-reports of an illegal activity. Concerns about the use of the information, even with guarantees of confidentiality and anonymity, usually result in a number of respondents misrepresenting their behavior when responding to a survey or questionnaire.

In addition, it is difficult to assess the impact of alcohol and drug abuse in actual work settings since outcome measures (such as performance ratings and absenteeism) can be affected by a number of variables besides substance abuse. In order to gauge the effect of a single influence on an outcome measure, a certain amount of control over other influences is necessary. It is difficult to achieve this control in actual work settings, since such control can interfere with production or accomplishment of job duties.

Some recent studies have used the results of drug tests to establish illicit drug use. A positive urine test for a drug cannot be used to prove impaired performance or to infer "being under the influence," but it does prove recent use of that drug. As such, it can be used as an objective marker of recent illicit drug use and has considerable research utility. These newer studies have also had larger sample sizes, which has allowed researchers to create control or comparison groups and to hold constant other factors while zeroing in on the effects of illicit drug use on organizational and work behavior.

In 1989, Jacques Norman and Stephen Salyards studied the work performance of illicit drug users employed by the U.S. Postal Service. In this research, 9 percent of all eligible applicants in the study sample tested positive for illicit drug use during routine preemployment drug screening. Of this number, nearly two-thirds (63 percent) tested positive for marijuana and 25 percent tested positive for cocaine. Preemployment drug test results were not used in the hiring decision, so the relationship between drug test results at the time of hire and subsequent organizational behavior could be assessed.

In the followup period of employment studied, employees who tested positive as applicants were absent 43 percent more often than those who tested negative. Those who tested positive for cocaine used leave time three times more frequently than those testing negative. Furthermore, employees who tested positive for any drug had a 40 percent higher rate of involuntary terminations; those testing positive for cocaine were twice as likely to be involuntarily terminated.

Jane Frieden, writing in a 1991 issue of *Business & Health*, reported a related study of preemployment drug screening among 2,537 postal employees in Boston. In this sample, those who tested positive for marijuana use in the preemployment screen had 55 percent more accidents and 85 percent more injuries than those who tested negative. Cocaine users had 145 percent more absenteeism and marijuana users 78 percent more absenteeism.

Michael McDaniel's 1989 research studied 10,188 individuals who entered military service within 1 year of completing a self-reporting illicit drug use survey; he related these

self-reports to later discharge from military service for "failure to meet minimum behavioral or performance criteria." Sixteen percent of the sample were discharged for being unsuitable for the military. Results indicated that, in general, the earlier in life one reported using illicit drugs and the more frequently one reported using illicit drugs, the greater the probability of being found unsuitable for employment by the military.

Impact: Work Organizations

Several recent studies have provided more specific and rigorous evidence of the actual impact of illicit drug use on organizational functioning and performance. For instance, in 1989, Dennis Crouch and his associates reported a study at Utah Power and Light that investigated the organizational costs (in terms of the frequency of absenteeism, medical benefits usage, and number of accidents) associated with employee use of illicit drugs. Company records were used to develop four separate groups. The first group was composed of employees who had tested positive for illicit drugs during a urine test, the second was made up of employees who had voluntarily requested help for an illicit drug problem from the company's EAP, and the other two groups were comparison groups matched on relevant variables (for example, sex and income).

Results showed that employees who tested positive for drugs had an unexcused absence rate that was 240 percent higher than their matched control group. Total absences (which included sick days, vacation days, and unexcused absences) were 28 percent higher. In addition, employees in the drug-positive group were five times more likely to be involved in an accident than were those in the control group, and they were found to be at fault in 80 percent of the accidents in which they were involved.

This study also looked at the cost-effectiveness of the company's EAP. An estimate of major costs associated with the program in 1986 and 1987 was $482,000. In contrast, the estimated savings to the company—from reduced accidents, absenteeism, and turnover—was $662,140. This represents a net cost savings of approximately $180,000 over the course of 2 years.

John Sheridan and Howard Winkler conducted a large-scale study at Georgia Power Company in 1989. More than 1 million company records were analyzed to compare work-related behaviors (e.g., accidents, benefits usage, turnover, and absenteeism) between illicit drug users and nonusers. Users were identified through participation in the company's EAP, by testing positive for illicit drugs, or by having drug-related medical treatment.

Matched control groups were also developed for this study. One control group was composed of employees who had undergone for-cause drug testing that was negative. A second group was composed of employees who presented at the EAP for problems other than illicit drug use, and a third group was composed of employees who were dismissed by the company for reasons other than illicit drug use. Finally, a random group of other matched employees was developed.

Results showed that medical benefits usage and absenteeism clearly differentiated employees using illicit drugs from their nonusing counterparts. For example, employees treated for a drug problem averaged $1,347 in annual medical benefits usage, compared with an average of $590 for the total work force. Differences were also found in measures of absenteeism caused by sickness and those caused by various types of unpaid leave (docked time, disciplinary suspensions, etc.). Annual absenteeism averaged 91 hours for employees

treated for illicit drug use, while the average absenteeism rate was 41 hours for the entire company.

The study also examined the costs and benefits of Georgia Power's drug testing program with respect to discharge of employees found to be using illicit drugs. Results indicated that the cost for discharging an employee using illicit drugs was between $7,287 and $8,063. Elements considered in this average were program costs, the expense of labor arbitrations and other legal challenges, and turnover costs (including lost productivity, training, and recruitment expenses). On the other hand, discharging these employees was estimated to save the company approximately $1,733 per worker per year. When factors such as the expected tenure of the discharged employee, inflation rates, and turnover allocation are considered, the discharge and replacement of 198 illicit drug users between 1983 and 1987 was estimated to save the company between $294,000 and $1,690,327. This result is one of the few empirical findings to date about the impact of drug testing—a point we will return to later when discussing drug testing issues.

Impact: The Larger Environment of Work and Society

The overall economic costs of alcohol and drug abuse have been estimated in a series of studies conducted by the Research Triangle Institute, based on a number of assumptions about the extent of abuse and consequences for the workplace and for individual workers. More recently, an update of these studies was conducted by Dr. Dorothy Rice and other researchers at the University of California at San Francisco. They used similar statistical and economic models to estimate that the total cost to American society of illicit drug use was $42.2 billion in 1988, with another $85.8 billion for alcohol abuse. These estimates include costs for law enforcement, legal proceedings, property destruction, and the treatment, lost productivity, and early death of substance abusers.

The significance of the drug use problem is accentuated by the associated increased risk of HIV infection—either through injected drug use or the lowered impulse control that can result from alcohol or drug use. Also, the rise in health care costs and the economic impact of these increases on employers—who pay for a significant amount of all health services in the United States—make the problem of alcohol and drug abuse among workers (whether drugs are actually used on the job or not) of even greater concern.

Impact: Business and Social Attitudes

Business organizations such as the Conference Board, the U.S. Chamber of Commerce, and the National Federation of Independent Businesses have conducted workplace alcohol and drug abuse programming for their employer members since the mid-1980's. In late 1989, a coalition of 14 major corporations formed the Institute for a Drug-Free Workplace. The Institute studies and provides input to the business community about workplace substance abuse issues, including the use of testing programs as part of an overall workplace response.

Shortly after its inception, the Institute commissioned a Gallup survey of full-time workers regarding their attitudes about substance abuse in the workplace. The worker sample was 42 percent professional, 25 percent blue collar, 20 percent managerial, and 10 percent clerical. When asked, "What is the greatest problem facing the United States today?" 28 percent responded "drugs," the most frequent answer. Almost one-half (49 percent) acknowledged that illicit drug use occurs in their own workplace, and 22 percent said it was somewhat widespread. Thirty-two percent said that sales of illicit drugs occur at work, while

forty-one percent said that illicit drug use by other employees in their work organization seriously affects their own ability to do their job. Approximately 1 in 12 reported being offered illicit drugs at work, and 1 in 14 had been directly approached to buy illicit drugs.

In early 1989, Marsh & McLennan, a leading insurance and reinsurance broker, commissioned a subsidiary, William M. Mercer Meidinger Hansen, Inc., to survey the *Fortune* 1,000 corporations, all 50 State Governors, and the mayors of 64 leading cities regarding illicit drug use in the workplace. Eighty-eight percent of those who responded indicated that illicit drug use is a "very significant" problem, more than double the number who thought so only 5 years ago. More than half of the respondents (54 percent) estimated that between 6 and 15 percent of their current employees are using illicit drugs. Thirty-seven percent of the chief executive officers and 29 percent of the human resources executives responding felt that illicit drug use cost their company as much as 5 percent of their annual payroll. Furthermore, 81 percent predicted that the situation will worsen if no additional public resources are devoted to solving the problem.

Facing the Challenge

All employers in the United States today, from smaller entrepreneurial businesses with 20 or fewer employees to *Fortune* 500 companies, face the challenge of building an effective workplace alcohol and drug abuse program. Numerous developments point to the need for evaluating programs, enhancing policies and program activities, and significantly expanding workplace substance abuse programs. Even so, positive changes have occurred: increased awareness, sharper perception of the employer's responsibility to act, improved technology for drug detection and treatment, improved insurance coverage for substance abuse treatment, greater attention to the issues of health care costs and containment, and greater awareness of the likelihood of legal challenges.

All workplaces need to seek the best resources for developing effective programs. This means examining programs such as the model efforts presented in chapter 5. It means making use of resources developed by professional and trade associations such as the Employee Assistance Professionals Association and the Employee Assistance Society of North America, the Conference Board, and the U.S. Chamber of Commerce's National Chamber Foundation. It also means responding to the Federal Government's leadership, through the Drug-Free Workplace Act of 1988, the Anti-Drug Abuse Act of 1986, and the 1986 Presidential Executive Order calling for a drug-free Federal workplace. Finally, it means studying the growing knowledge base on this subject in popular and scholarly management literature and in related fields such as alcohol and drug abuse research, behavioral sciences, medicine, and public health.

The essence of good strategic planning for any employer, large or small, is to determine how particular program models, activities, or services fit with the defined needs of the organization. To succeed over the long run, programs must be designed to fit the particular circumstances of the given employer.

Employers in the 1990's are viewed as having major responsibility for shaping the environment and social conditions. The notion of private enterprise in isolation has been replaced by the concept of corporate responsibility, an inevitable byproduct of the increasing interdependence of all areas of society and the increasing influence of the workplace. This is not a new concept. Back in 1986, U.S. Chamber of Commerce President Dr. Richard Lesher called on business people to "take the lead in the campaign against drug abuse in our

society." Business leaders, Lesher asserted, have great power and influence in their communities, and are looked to "for leadership in setting standards of personal behavior" and for guiding public debate on issues like substance abuse. His call to action is just as relevant today.

Employers have the resources and the leverage to motivate workers and the responsibility (as seen by the community at large) to "do something about drug abuse." This seems to be in keeping with employers' self-interest—enhancing the quality and productivity of their work force, decreasing accidents and poor decisionmaking, and controlling the skyrocketing expenditures on health insurance benefits and worker compensation claims. Perhaps most important is the role that employers may have to prevent alcohol and drug abuse and related problems among workers and their families, as well as their influence in building healthier and safer communities.

2. The Response

Current Workplace Programs: Successes and Shortcomings

The central principle of this publication is that a strategy is needed for planning and implementing a workplace alcohol and drug abuse program. Strategy is, in fact, commonly regarded as crucial to success in activities of all sorts, not just those concerned with substance abuse prevention or remediation. Management research has shown that strategy is the single most important differentiating factor between successful and unsuccessful businesses, and between corporate leaders and followers. An effective strategic plan, coupled with management commitment and deployment of adequate resources to implement the plan, is the single most important ingredient for a successful workplace substance abuse effort.

Employers have learned a great deal about the challenge of workplace alcohol and drug abuse, and much is happening to help employers determine the nature and extent of their response to this challenge. Interest in this topic has been intense since the mid-1980's. Many public and private organizations have reexamined and restructured their activities to assist workers with alcohol and drug abuse problems. Corporate policies have been initiated or rewritten; management training has been provided; consultants or outside employee assistance program (EAP) contractors have been hired; and in-house EAP staff have been trained in specific aspects of illicit drug use.

Drug testing has become an acceptable practice, especially in safety-sensitive industries. Many conferences, continuing education seminars, and special events sponsored by business and industry organizations have been conducted on alcohol and drug abuse, in particular on issues surrounding drug testing. Coverage in business periodicals and business-oriented television and radio shows has proliferated.

Even workplaces that do not have a program to address alcohol and drug abuse have assigned a human resources or medical department staff person to investigate the problem or have started a committee or task force.

The complexity of the current situation calls to mind the ancient Chinese language symbol for crisis—it contains elements of both danger and opportunity. The opportunity comes from the energy and motivation to consider new programs and practices, some of which can be genuine improvements in how workplaces deal with alcohol and drugs. The danger is that this same energy comes in an atmosphere of urgency to act immediately, sometimes a panic response of "we've got to do something—anything!—about alcohol and drugs!"

These pressures come from many sources—employers' perceived self-interests (to increase productivity and profits), a desire to help troubled workers, litigation or the threat of it, the desire to be seen as socially responsive or "on board" with the latest business community trend, and the requirement to respond to generic legislation such as the 1988 Drug-Free Workplace Act or to more specific laws and regulations such as those governing the transportation and nuclear industries.

Responses generated only by such pressures, without an examination of the larger issues of strategic planning and without a concrete vision of what a workplace substance abuse program can achieve, are likely to fail for two reasons. First, they tend to be hastily conceived and sloppily executed, without regard for the requirements for successfully implementing major organizational change. (It must be understood that an effective workplace substance abuse program is a major organizational commitment.) The other reason for failure is that individuals and organizations often look for a quick fix, a magic-pill solution, such as testing for drugs or hiring a consultant to conduct management training sessions about some aspect of drug abuse. These interventions typically are inexpensive ways of seeming to respond to the problem without really doing so.

While some of the emerging organizations (such as drug testing laboratories) and consultants can indeed be part of an effective response to workplace substance abuse problems, there are no quick fixes. Despite the urgency of the problem, careful planning and deliberate action are required to create programs and install them properly.

Management research demonstrates rather convincingly that major organizational changes are unlikely to succeed unless they are well planned and follow certain basic principles about the psychological and structural realities of people and organizations. The more urgent the problem, or the more attention focused on it, the greater the temptation to apply a quickly conceived solution. This kind of solution simply will not work.

How can employers find information about successful alcohol and drug abuse programs? First, they should look for programs that utilize the best current knowledge about effecting organizational change. Most of this publication addresses this concern through one particular method, strategic planning.

Second, employers should look at what has already been done. This means examining what their peers have done to develop policies, supervisor and worker education programs, EAPs, and drug testing programs. It means looking at workplace substance abuse programs within the full organizational context—incorporating human resources, benefits, and corporate medical, legal, and other perspectives. It also means looking at the history of responses to alcohol and drug abuse in America, including those of employers, to see what we can learn from past experience.

Recent events do not comprise all of America's experience with illicit drugs. In 1970, several large companies sponsored the first Symposium on Drug Abuse in Industry to consider issues of policy, screening, and so forth. The first major workplace-based program against illicit drug use was started by the U.S. military in 1978. A significant historical experience base is available to draw upon, as well as a wide range of organization experience and workplace-related research.

The Foundation for an Effective Response Exists

The many available resources constitute a useful foundation for establishing an effective response to the problem of alcohol and drug abuse for both public and private employers:

- workplace policies on substance abuse in many thousands of public and private work organizations
- EAPs in an estimated 53,000 nonagricultural worksites with more than 50 full-time employees, and the experience that has built up around them (see Hartwell et al., *Prevalance, Cost and Characteristics of Employee Assistance Programs*, Research Triangle Institute 1995 in the Bibliography)
- EAP services in 82 percent of companies with more than 1,000 employees
- fifty years of research on organizational change
- a large body of experience with strategic planning in American work organizations as a method for coping effectively with change
- current knowledge and practice in related areas such as human resource development, health care cost containment, health promotion, and creative use of employee benefits
- the larger changes in attitudes occurring in our society as exemplified by the considerable public and business community success of the Partnership for a Drug-Free America—a massive volunteer effort that has provided both general public and workplace education, primarily in the prevention area
- growth of substance abuse prevention and treatment programs, including many community-based prevention partnerships and coalitions
- leadership in developing and implementing model programs from the Federal Government, organizations such as the Employee Assistance Professional Association (EAPA) and Employee Assistance Society of North America (EASNA), and major employers
- research on prevention, intervention, and treatment methods related to specific alcohol and drug abuse programs in the workplace.

A 1990 update of a 1988 Bureau of Labor Statistics (BLS) study of more than 6,000 private nonagricultural businesses provides an interesting overview of responses by American employers to the workplace substance abuse challenge. (The 1988 study is described in more detail elsewhere in this publication; the 1990 update is detailed in a 1991 report by H.V. Hayghe in the *Monthly Labor Review*.) The 1990 update involved a carefully selected representative sample of the firms responding to the original survey.

The principal findings relevant to this discussion concern the study's identification of the presence or absence of a drug testing program, an EAP, and a written policy on workplace alcohol and drug abuse among the responding firms, analyzed by size of company (small, medium, or large, based on number of employees). For comparison purposes, both the 1988 and 1990 statistics are provided in table 1.

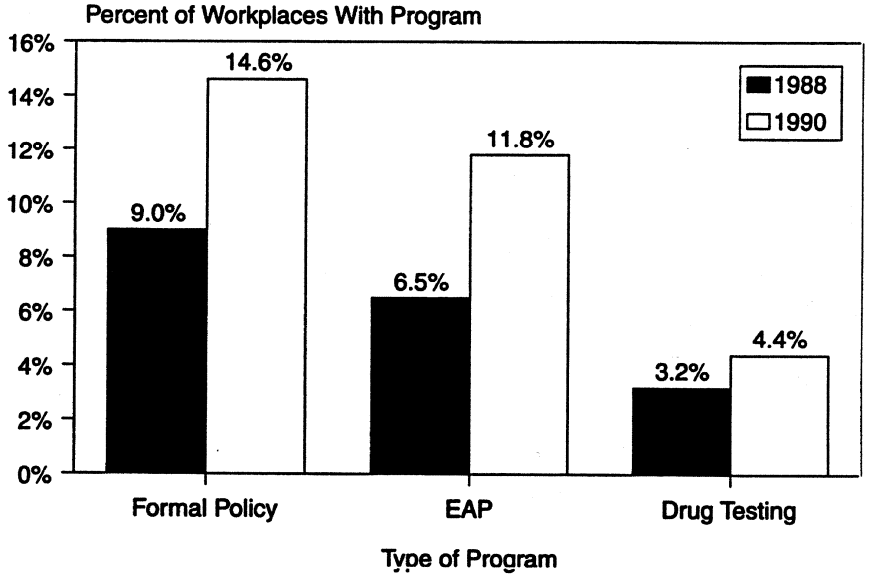
The 1990 followup survey indicated a significant change: during the two-year period from 1988 to 1990, there was a strong tendency among larger firms to establish anti-substance abuse programs and policies. Small businesses, which are far more numerous, were less likely to have such programs or policies (figures 6 and 7), although they also increased their

Table 1. Percentage of employers with drug testing programs, employee assistance programs, and alcohol and drug abuse policies

	Testing		EAP		Policy	
	1988	1990	1988	1990	1988	1990
Total	3.2	4.4	6.5	11.8	9.0	14.6
Size of employer						
Small (<50)	2.2	2.6	5.2	9.4	6.7	11.5
Medium (50–249)	13.8	26.1	19.8	39.3	37.1	53.6
Large (250+)	31.9	45.9	51.3	78.8	55.7	74.3

Source: 1988 BLS survey of employer antidrug programs and 1990 followup study.

Figure 6. Employer programs to eliminate drug use in the workplace—by type of program



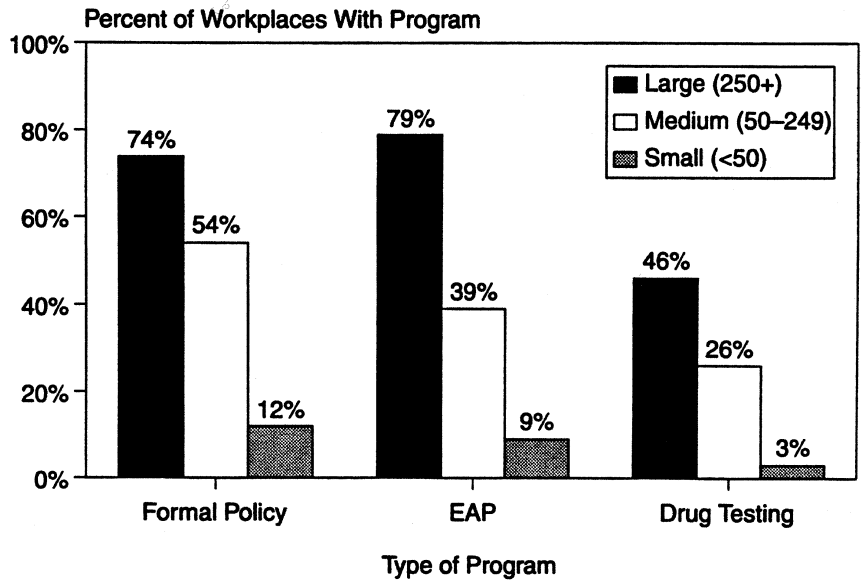
Source: 1988 BLS survey of employer antidrug programs and 1990 followup study.

efforts. Much needed research is now under way to determine the major motivators and barriers that affect the smaller businesses' willingness and ability to implement anti-substance abuse programs.

Furthermore, the BLS study shows that a number of companies dropped testing programs they had in operation in 1988; this situation was offset by companies that started programs, so the overall number of companies with testing programs was up from 1988. Cost-effectiveness and legal considerations were frequently paramount in the decision to drop a drug testing program. A number of court decisions and State laws had a mixed impact on the ability of employers to test and were at the center of their legal considerations.

While some of the small businesses surveyed (36 percent) had dropped their EAP, overall the percentage of small businesses with EAPs increased by 80 percent from 1988 to 1990.

Figure 7. Employer programs to eliminate drug use in the workplace in 1990—by size of firm



Source: BLS 1990 followup study.

Even so, fewer than 10 percent of small businesses surveyed offered EAP services to their employees, compared with almost 75 percent of larger employers. We will return to this finding in chapter 7, which is concerned with special programs for small businesses.

A Comprehensive Alcohol- and Drug-Free Workplace Program

In the remainder of this chapter, the knowledge base on the five elements of a Federal Comprehensive Drug-Free Workplace Program will be reviewed. Those elements are

1. a comprehensive written *employer policy*
2. *supervisor training*
3. *employee education*
4. availability of *employee assistance programs (EAPs)*
5. identification of illicit drug users, including *drug testing* on a controlled and carefully monitored basis.

In addition, some basic concepts about strategic planning and the incremental change concept will be presented. The 10 steps for implementing a strategic planning model are discussed in chapters 3 and 4. In chapter 5, case examples for each of the five essential elements show how strategic planning and incremental change can benefit the development or enhancement of such efforts.

1. Employer Policy

In 1990, the National Institute on Drug Abuse (NIDA) supported a comprehensive Policy Models project to find and review exemplary employer policies regarding workplace alcohol and drug abuse. A total of 183 workplace policy statements of varying degrees of quality and intensity were reviewed. From this group, 101 were included in a primary database and are available through CSAP's toll-free National Workplace Helpline (see Workplace Resources following chapter 7). The intent is to match an employer (or someone helping an employer) seeking policy development assistance with an existing workplace policy already developed by an employer with similar needs or background.

In the Policy Models study, the main components of a workplace substance abuse policy were determined to be

- general statement
- prevention
- training
- security and identification
- drug testing
- treatment.

A variety of specific, but not necessarily complex, issues need to be covered when an employer develops a clear and comprehensive written policy on alcohol and drug abuse. Usually an employer will need to address each of these six major policy components as well as other relevant issues, such as labor agreements, Federal and State requirements, and the decision to separate or combine alcohol and drug abuse policies.

2. Supervisor Training

Any successful workplace substance abuse program requires informed, well-trained managers and supervisors. Supervisors need to know what policy their organization follows with respect to alcohol and drug abuse in the workplace, how to deal with employees who may have an abuse problem, and what resources are available to back up their actions. While controversy abounds concerning whether supervisors should be trained in the specifics of alcohol and drug abuse and ways to detect employees who may be abusing, there is unanimity that supervisors need to thoroughly understand the organization's policy. They must also know how to detect and respond to performance problems and how to access components of the workplace substance abuse program such as the EAP.

A number of the resources listed in the back of this book can be part of a supervisor training program. Such a program could be offered as a specific freestanding activity to address alcohol and drug abuse issues, or it could be integrated with other training offered to supervisors, such as conducting performance reviews, acquiring basic supervisory skills, and working with problem employees.

3. Employee Education

A substance abuse policy and program will be accepted and supported by a work force only if employees clearly understand its rationale. This requires an employee education

program, ideally undertaken prior to initiating the policy and program. Prevention and treatment information also can be presented during employee education sessions. Because employees are often adversely affected by the substance abuse of a family member, these sessions should also address family issues. Numerous resources for employee education programs are provided in the back of this book.

4. Employee Assistance Programs

EAPs have become increasingly available and visible in American workplaces during the past 20 years. The 1992–93 Research Triangle Institute Survey by Hartwell and colleagues found that approximately 33 percent of the worksites with 50 or more employees offered some type of EAP service, and that over 22.7 million workers have access to EAP services. A majority (76 percent) of large (1,000 or more employees) workplaces have EAPs, while only 21 percent of small businesses (50–99 employees) have an EAP. These service programs are typically offered as an employee benefit at little or no cost to the worker and can help troubled employees deal with problems such as alcohol and drug abuse, marital and family problems, financial difficulties, and preretirement planning. EAPs represent an increased understanding by employers of the impact that workers' unresolved personal problems can have on organizational performance. EAPs are a key element of an alcohol- and drug-free workplace program and can be a resource to an employer developing the other elements of a comprehensive alcohol- and drug-free workplace program.

EAPs grew out of occupational alcoholism programs first established in American industry in the 1940's. More comprehensive programs began in the early 1970's, when changing corporate and social values began to press for greater intervention at the workplace to help troubled employees and their families. EAPs exist today in virtually every type of work organization: private industry, the U.S. Government, and educational institutions. Both unions and management have supported EAPs and their potential for enhancing employee well-being and organizational performance. In fact, EAPs are often seen as an important advance in the long search for methods to improve worker performance and meet organizational goals.

Typical EAPs are relatively small-scale programs, staffed by a handful of professionals with support staff. They provide confidential counseling and referral services to employees and their families. EAPs have been adapted to meet the different needs of workers and employers. Some programs are operated internally, while others are conducted by outside consultants or consulting firms. Some are operated by unions, others by a consortium of employers from a given geographic area or by type of industry—an especially viable option for smaller employers.

Most EAPs provide only crisis intervention and referral services, plus some educational materials, while a few are full-service programs and may include treatment. Most offer some sort of service to persons with illicit drug use problems. Supported by NIDA and the private sector, Thomas Backer and Kirk O'Hara undertook a 3-year National Study of Workplace Drug Abuse Programs, examining illicit drug use treatment services provided through American EAPs. They report their findings in their 1991 book, *Organizational Change and Drug-Free Workplaces: Templates for Success.* The study had two major data collection phases. The first phase undertook a national survey of 1,238 EAPs. The second phase involved 201 intensive telephone interviews with a stratified random sample of survey respondents.

Health care institutions and government agencies had the largest percentage of EAPs (17 percent and 16 percent, respectively); industrial manufacturing firms were third (15 percent). EAPs from 3 to 5 years old comprised 33 percent of the survey sample, but a sizable portion (16 percent) had been in existence for more than 10 years. Sixty-four percent of the EAPs were housed in the organization's human resources or personnel department. A fair number (16 percent) were in the medical department, and 12 percent reported directly to top management.

The two most common reasons survey respondents gave for having an EAP were "returning employees to productive work" and "providing an employee benefit." This study determined that the most basic component services of an EAP were offered by almost all such programs. That is, roughly 95 percent of the EAPs in the study sample offered the basic services of crisis intervention, inpatient and outpatient referral, family counseling referral, and followup. These basic component services or dimensions were defined by EAP researchers Paul Roman and Terry Blum in a 1988 report. On the other hand, very few (9.7 percent) EAPs in this study offered significant in-house treatment. Half of all respondents take an alcohol and drug abuse history regardless of the presenting problem, but about 20 percent may not take such a history at all.

Assessment and referral procedures for substance-abusing workers varied greatly, from informal recommendation to structured assessment and diagnosis. Followup and aftercare services for employees receiving treatment for alcohol and drug abuse were also quite varied.

Most programs (73 percent) saw an average of between 1 and 10 persons per month for problems that were identifiably related to alcohol or drug abuse. Self-referrals were the primary source of EAP clients—over 50 percent of all clients seen by EAPs nationwide.

Only 5 percent of the respondents reported that their EAP had been the object of legal action. Interviewees were most likely to identify confidentiality issues as the greatest area of potential legal liability, but duty-to-warn issues were also part of this concern. Finding the balance between these two issues can be difficult indeed. Misdiagnosis and inappropriate referrals were also commonly mentioned, and most respondents felt that well-defined policies and improved recordkeeping were the best ways to prevent legal entanglements.

The single most pressing issue reported by survey respondents was the provision of adequate alcohol and drug abuse services by Health Maintenance Organizations (HMOs). Second was worker and public safety related to alcohol and drug abuse. When asked how effective the EAP had been in addressing workplace substance abuse, only 34 percent felt they had been "very" or "fairly" effective. Respondents felt they had been most effective in helping troubled workers and increasing morale and job satisfaction. They gave the lowest rating to their performance in increasing vigilance toward worker and public safety; this outcome contrasted with their own urgent concern for worker and public safety related to alcohol and drug abuse.

5. Drug and Alcohol Testing

The identification of illicit drug users and alcohol abusers, including drug and/or alcohol testing on a controlled and carefully monitored basis, should not be overlooked by employers. If testing is to be conducted, it should be used as part of a comprehensive substance abuse program and should be explained to supervisors and workers well in advance of its implementation. Some federally regulated industries are required to test employees in certain types of occupations (safety and other sensitive positions). In addition, when an employer

tests job applicants for illicit drugs, a strong message is sent that illicit drug users need not apply.

The different types of employee drug and alcohol testing will be covered later, but it is important to note that there are other methods to detect illicit drug users and alcohol abusers in the work force and that each company should develop a program that will fit its own needs, risks, and problems. However, employers are strongly cautioned against trying to diagnose illicit drug users and alcohol abusers in the workplace and should focus their efforts on training supervisors to document employee performance and conduct problems accurately, and to do so in a timely manner. While drug and alcohol testing is one way to identify illicit drug users and alcohol abusers, it can also be an effective tool to deter workers from ever starting to use illicit drugs and to help identify drug- and alcohol-related accidents. However, it should never be considered a quick fix or cure-all to eliminate illicit drug users or alcohol abusers from the workplace.

Overview of Program Models for Workplace Alcohol and Drug Abuse

The five principal elements of a model Comprehensive Drug-Free Workplace Program (originally defined by NIDA and continued under the auspices of CSAP) have been combined to various degrees in a number of different program models now operating in both public and private organizations. Eight different program models are most frequently observed today.

1. Education-Only Program

Some organizations may wish to begin their efforts to combat alcohol and drugs in the workplace with educational programs for workers, supervisors, and executives. Such programs can offer helpful guidance on recognizing problems related to substance abuse, accessing available community resources, etc. To be effective, this kind of program requires a training director with the knowledge and skills to present appropriate educational materials, sometimes utilizing an outside professional trainer or consultant.

However, in most instances education alone will not prevent alcohol or drug abuse or solve a workplace's substance abuse problem if one exists. Education usually should be considered as only a first step toward raising awareness and developing and implementing a comprehensive program, as expressed in the incremental approach to change.

2. Referral-Only Program

Programs of this type combine in-person or telephone referrals with community resources (self-help programs, substance abuse treatment facilities, etc.). Sometimes the referral contact person may engage in crisis intervention counseling with an emotionally distressed individual because such intervention may be necessary in order to learn enough to make an appropriate referral.

In some communities, crisis intervention services may be available from an outside agency, so that the contact person has only to give a telephone number to the worker seeking assistance. This type of program typically does not provide financial or case management support for services provided to the employee or family member.

3. Workplace-Run Program With Outside Treatment Resources

In this model, initial assessments of (and interventions with) employees are offered within the workplace (usually by an internal EAP staff member), as are referral and crisis intervention services. These employer-provided resources are combined with direct treatment provided by an outside agency and supported by the employer, whether through direct payment or insurance coverage.

The EAP director, counselor, and other staff (if any) are employees of the work organization. EAP staff members often develop materials and train senior management and line supervisors, educate employees, and develop and revise policy. In addition, EAP staff members work very closely with supervisors when employees are referred; identify and assess the suitability of outside treatment providers; develop and disseminate EAP and other materials related to substance abuse in the workplace; and assist treatment providers with case management and with issues surrounding the employee's return to work.

4. Contractor-Run Program With Outside Treatment Resources

In this model, referral, crisis intervention, and short-term treatment services are coordinated and offered by an outside contractor (often an individual EAP consultant or EAP consulting firm) retained by the employer for this specific purpose. Many of the responsibilities listed above for the workplace-run program (see model 3) may also be met by the contractor.

Such consulting firms are now readily available in most larger cities, and some are able to provide national and regional services for multisite workplaces as well. Some firms also provide managed health care services and access to drug testing services. The contractor-provided services are combined with direct treatment services provided by an outside agency and supported by the employer, through either direct payment or insurance coverage.

5. Mixed Model Program

Large, multisite work organizations have begun using this approach to address organization requirements and worker-family needs that may vary greatly from site to site. Economic, regulatory, and service-related issues may also be involved, and an employer may realize significant cost savings by using outside consultants for some worksites and an in-house program for others. In addition, it may be cost-effective to contract for some services—such as a telephone hotline or drug testing services—rather than trying to provide such services in-house, while retaining in-house EAP staff to provide the more traditional services of employee education, assessment, and referral. In most of these arrangements, management training, program development, administration, and policy are all handled by the corporate office in-house program.

A corporation may manage the overall program through an in-house coordinator based at the corporate headquarters and then contract with consultants to provide special services or to work at specific locations. This arrangement may be a good option for providing services to remote worksites, for locations with fewer than 100 employees, or for worksites that have unique requirements.

6. Consortium-Run Program

In this model, a group of work organizations (or a combination of employers and unions) jointly develop and fund a program. Typically, the workplaces belonging to the consortium are located in a defined geographic area, and often they are within the same or related industries. There can be several advantages to this type of program. Combining resources increases buying power, and economy of scale can make the program more affordable for all members of the consortium. Alcohol- and drug-free workplace services become more affordable, as do related services such as health insurance, workers' compensation insurance, substance abuse treatment, and legal assistance. In addition, experienced members of the consortium may be able to assist new members in developing their workplace programs (e.g., a large company may help a smaller company develop a written policy or meet Federal drug testing requirements).

The consortium approach is frequently used by organizations too small to have independent programs; it may be facilitated by a local Chamber of Commerce, business- or industry-specific association, local nonprofit substance abuse organization, State substance abuse office, or other group. An early example was the Downtown Drug Center in New York City, which was jointly sponsored by AT&T, the American Stock Exchange, Chemical Bank of New York, and Merrill Lynch. Two other examples of consortia programs are described in greater detail: the Entertainment Industry Referral and Assistance Center (in chapter 5) and Employee Assistance of Central Virginia (in chapter 7). In addition, union-operated consortia also exist (see below, Member-Run Program) for specific occupations or industries.

7. Member-Run Program

Some organizations, especially unions, have developed workplace alcohol and drug abuse programs, which they operate on behalf of members and their families. Such programs are often called a Member Assistance Program (MAP) or a peer referral EAP and may be especially appropriate for organizations that are unionized or in which workers have considerable freedom from direct supervision. In most of these arrangements, peer counselor training, program development, administration, and policy are handled by a central in-house office, and the costs of the program are paid mostly from membership dues.

Agreements with management or with professional associations determine lines of authority and staff responsibilities (e.g., for a hotline, drug testing, and training). The MAP trains volunteers to act as change agents in the workplace—especially to motivate their coworkers to seek assistance for their problems by seeing a professional MAP counselor, who may be an in-house employee or under contract. Direct treatment is normally provided by an outside agency and supported by the organization, either through direct payment or insurance coverage.

Since 1980, the Association of Flight Attendants, affiliated with the AFL-CIO and representing 30,000 flight attendants employed by 19 air carriers in 45 cities, has operated such a Member Assistance Program. This MAP provides peer intervention, referral, and other support services using a select group of more than 100 volunteer flight attendants who have received special training. This strategy takes advantage of the special dimensions of flight attendants' work and social environments. Other industries and professions that have developed similar types of programs include railways, aviation, trucking, maritime, tunnel workers, and the medical and legal professions.

8. In-house Full-Service Program

Only a few workplaces try to do it all, that is, provide all elements of an alcohol- and drug-free- workplace program and a full range of treatment services. However, some Federal agencies (mainly the military) and a few companies do operate on this model. The complexities of maintaining a comprehensive range of treatment facilities and hiring appropriate professional staff are such that even most large, multinational corporations do not find it cost-effective to operate a completely in-house program.

Organizational Change

Good strategic planning is based on the theory and practice of organizational change, a subject of study for managers and management scholars for over 50 years. Strategic planning involves a specific set of techniques for bringing about significant organizational change, techniques that are today in wide use by many *Fortune* 500 companies, as well as by other private and public organizations.

The following principles are based on assumptions about organizational change that have been well documented in academic literature and management research. They have been publicized in such well-known books as Peters and Waterman's *In Search of Excellence,* Rosabeth Moss Kanter's *The Change Masters,* and Peter Drucker's *Innovation and Entrepreneurship.*

- Effective change begins with setting goals for the change program, expressed in measurable terms and set into a formal organizational policy.
- Planning to implement these goals needs to be a systematic process, rather than haphazard or informal, with adequate documentation of the steps by which the goals will be achieved. (This process is called the strategic plan.)
- Effective changes in worker behavior, especially in an area as sensitive as alcohol and drug use, require certain corresponding changes in organizational culture; the culture must, to some extent, have been supporting and reinforcing the behaviors that are no longer desired, which adds to the complexity of change.
- To be successful, a change program must be developed through active participation in the planning process by all those in the organization who will have to live with the results of the change; i.e., representatives of workers at all levels in the organization.
- Once successful, a change program must be evaluated and improved to maintain its vitality and viability over time.
- A change program must be integrated effectively with existing successful organizational components; managers contemplating changes must remember that old workplace maxim, "If it ain't broke, don't fix it."

Incremental Change

Increasingly, scholars and consultants on organizational change, as well as those implementing major change programs in work organizations, see such a program not as a single massive intervention, but as an incremental process. James Brian Quinn describes this process in his book *Strategies for Change: Logical Incrementalism.*

> The most effective strategies of major enterprises tend to emerge step-by-step from an iterative process in which the organization probes the future, experiments, and learns from a series of partial [incremental] commitments rather than through global formulations of total strategies.... Such logical incrementalism is not "muddling".... [It] honors and utilizes the global analyses inherent in formal strategy formulation models.... (p. 102)

Rosabeth Moss Kanter, in *The Change Masters* (1983), reinforces this concept in speaking of "the building blocks of major organizational change" as "microinnovations" that come from numerous places within the organization. These are the building blocks for the new construction, and the key is to have an overall vision of how they fit together. It is necessary to see change in this larger context, using an integrative approach to problem solving.

In a comprehensive 1983 review of the empirical and scholarly literature on determining factors in individual and organizational change, Edward Glaser, Harold Abelson, and Kay Garrison cite a number of formulations that include factors related to incremental change. For instance, many empirical studies of successful planned change have identified the concept of "trialability, divisibility, or reversibility" as a key factor in success—trying out innovation one step at a time, without calling for an irreversible commitment of the organization to the entire change. Not only is there less risk in such an approach, but there is also the opportunity to observe how the first changes work out, to learn from them, and to use the positive feedback they provide as part of the motivator to introduce more of the change.

This approach certainly fits with the comprehensive, multicomponent approach to workplace alcohol and drug abuse programming advanced in this publication. Five major elements of a strategic plan—policy, supervisor training, employee education, EAP, and drug testing—have been discussed. A 10-step strategic planning process to provide a framework under which change can take place is presented in the next chapter. However, in many organizations, the resources and the will to implement all of these elements and steps may not be present simultaneously.

Making the Three Commitments

This imbalance brings us back to the three commitments from management—leadership, resources, and strategic planning—needed for an effective workplace alcohol and drug abuse program. Part of the value of strategic planning is that the other two commitments can be viewed from an integrated perspective.

In *The Change Masters,* Kanter emphasized the importance of integrative approaches to problem solving as a key to effective innovation. Any problem requiring change must be seen in its larger context, she said, thus opening the door for challenges to conventional wisdom and to solutions that draw upon natural synergy and the combined efforts of many people.

Certainly this advice applies in the alcohol and drug abuse area. As will be seen in the discussion of special issues in chapter 6, employers face a bewildering set of complexities and challenges with respect to alcohol and drug abuse in the workplace. While we know that substance abuse programs are one aspect of overall organizational efforts to maximize human resources, such efforts to change the workplace and workers differ in many respects from the ordinary human resource development program.

Substance abuse, it is said, is a disease of denial. Breaking through the denial is not easy, and many change efforts may be resisted for this reason alone. Whole organizations can deny that problems exist, despite overwhelming evidence to the contrary. An organizational pattern of denial can resemble the family dynamic in which parents are unable to accept the reality that their child has a problem with alcohol or drugs. This kind of blindness and denial can have sad and dangerous consequences.

One stage in the denial response appears on the surface to be a healthy recognition of the problem, but the reaction is to continue the denial by saying, "I know there was a problem but I've solved it." Much of the motivation for quick-fix solutions to substance abuse problems in the workplace and elsewhere derives from this common avoidance pattern. Management should know about this psychological reality and be on guard when it is manifested.

Any change effort concerning alcohol and drugs is complicated by the fact that most drug use in the workplace is illegal. Also, change strategies must contend with the reality that many social reinforcers may indirectly support alcohol and drug abuse, on or off the job. For a problem-solving approach to succeed, it must be flexible enough to adjust to rapid changes in substance abuse patterns and to social perceptions about using alcohol and drugs. Management that is cognizant of the dramatic changes that occur in the substance abuse area will devise strategies to cope with these inevitable changes. Examples include recent developments in legal cases involving drug testing, changing medical technology and health insurance provisions, and the emergence of laboratory-created "designer drugs," to name just a few. Thus, tomorrow's substance abuse crisis will look only somewhat like today's, and the effective program will be prepared to deal with change.

3. Planning a Workplace Alcohol and Drug Abuse Program

This chapter presents a strategic planning process for developing or enhancing a workplace alcohol and drug abuse program, and describes the three preliminary activities that are critical for program development: establishing job performance standards, assessing needs, and evaluating current resources and responses. These activities prepare the organization to complete the major steps of strategic planning. Each of the 10 major steps in the strategic planning process is outlined. These steps contain the essential program components—policy, supervisor training, employee education, Employee Assistance Programs (EAPs), and drug testing. Chapter 4 describes the program components included under the 10 steps.

Organizational commitment of leadership and resources is assumed to have been made by the time the strategic planning process begins, since both leadership and resources are essential to carrying out a strategic plan. Moreover, a major organizational change like a workplace substance abuse program requires regular reexamination and revitalization of these commitments of leadership and resources.

Three Preliminary Activities

Preliminary Activity 1. Establishing Job Performance Standards

Job performance problems are the most immediate justification for intervening in a worker's suspected substance abuse problem. A work organization has a vital interest in the negative impact of employee alcohol or drug abuse on job performance, since such abuse can increase costs caused by absenteeism, turnover, lowered productivity, accidents, and other events. In order to measure performance deficits and take appropriate action, performance standards must be established for each category of job in a workplace. Consultants coming into a worksite frequently find that job performance appraisal and review systems are out of date, or lacking altogether; this may be true for both small and large organizations.

Therefore, the first step in setting the organizational frame for a workplace substance abuse program may be a commitment by top management to developing specific, operational job performance standards and a performance review system to measure their attainment by individual employees. Supervisory training will be necessary in order to implement the revised system, and some orientation for workers may also be of value.

Organizations need specific standards of performance for each job to provide an objective basis for documenting inadequate or deteriorating job performance. With the aid of established job performance standards, supervisors who detect deteriorated performance may suggest that the worker consult with the organization's EAP, or may engage in what has been called "constructive confrontation"—clearly delineating performance deficits and using the leverage of possible discipline or job loss to motivate the worker to seek help. While there have been efforts in some companies to help supervisors learn the signs and symptoms of alcohol or drug abuse, the majority opinion among both members of the business community and substance abuse professionals is that diagnosis of abuse problems is best left to those who have specialized training. Even with on-the-job education, supervisors cannot have the rigorous professional background needed to take on such diagnostic responsibilities; there may, in fact, be adverse legal consequences associated with doing so.

Education and prevention activities, important components of many workplace programs, do not depend on observed performance problems. They are intended to prevent performance from deteriorating in the first place. Moreover, standard methods of supervision and job performance evaluation, even if satisfactory for other purposes, may not be sufficient for early detection of alcohol and drug abuse problems. Supervisors may need to learn how to detect and understand subtle signs of deteriorating performance associated with substance abuse (e.g., impaired judgment and memory lapses). But these more subtle judgments, too, have to be made against some baseline.

Basing any action on job performance avoids unwarranted intrusion into employees' private lives. Moreover, if the threat of disciplinary action or dismissal is used to get a worker into a treatment program, ineffective job performance must be accurately documented, particularly in view of recent legal decisions that allow workers to bring actions against employers who discipline or dismiss without cause. In recent years, the legal philosophy underlying "employment at will" has been severely undermined—employers are no longer free to dismiss workers for any reason, including suspected abuse of alcohol or drugs. Due process must be followed, and increasingly there are both legislative impediments (e.g., State laws restricting the use of drug testing) and case law impediments (lawsuits that establish precedents for what employers can or cannot do) that govern the employer's range of action.

Many small or recently established work organizations may find a legitimate problem in developing job performance standards. Often, small organizations lack the kind of human resources system and documentation capabilities of large companies or government agencies; the organized bureaucracy of human resources development has not reached them. They may find it difficult to invest scarce time and financial resources in building such job performance standards for each class of worker, but there are many good business reasons for developing these standards. Trade associations, business and professional societies, and consultants may provide the expertise needed for this task.

Preliminary Activity 2. Assessing Needs

Organizations differ widely in the pattern and type of alcohol and drug abuse occurring in the workplace. Some of these variations relate to the community in which the company exists, the demographics (e.g., age range) of its work force, or other factors such as salary levels and degree of independence in work assignments (high salaries provide the financial resources to buy alcohol and drugs, and lack of supervisor observation of daily work performance can make substance abuse more difficult to detect). Being able to differentiate

between patterns or varying levels of alcohol and drug abuse or addiction and between the abuse of prescription drugs and illicit street drugs may also be important.

The types of illicit drugs presenting a problem will affect the focus of a program, because different drugs require different counseling and treatment approaches. For instance, a significant incidence of cocaine abuse may require special treatment services. Similarly, the extent of alcohol and drug abuse will determine the size of the potential caseload.

Several possible approaches can be used to estimate the nature and extent of alcohol and drug abuse within a work organization.

- National or regional studies of occupational substance abuse, especially those specific to the organization's area of work, provide rough approximations that may be a useful starting point.
- Local alcohol or drug abuse agencies (or health or law enforcement agencies) gather statistics that depict the extent and the consequences of workplace substance abuse.
- Local prevention and treatment programs, local chapters of the Employee Assistance Professional Association (EAPA), the National Council on Alcoholism and Drug Dependence, or other service-oriented associations typically have access to relevant statistics.
- Local or regional business and industry or trade associations may gather pertinent data. (Some national organizations of this sort can also provide statistical profiles.) For example, local medical societies with an Impaired Physicians Program may have statistics to offer a hospital planning a substance abuse program for its own staff. Local hospitals may also provide statistics on alcohol- and drug-related emergency room cases.
- Organizational staff (typically EAP personnel, human resources staff, or a special committee or task force of workers) may collect original data in the workplace. Anonymous questionnaires and interviews are essential to promote accuracy of reporting. In addition, human resources or medical department records can be analyzed for both direct and indirect statistics (number of persons hospitalized for substance abuse problems, absenteeism rates, turnover records, etc.).
- Outside consultants, such as management consultants or faculty from a local university, may gather original data.
- Data gathered about the extent of alcohol and drug abuse in the community may also be relevant.

Preliminary Activity 3. Evaluating Current Resources and Responses

The nature and scope of a workplace alcohol and drug abuse program will depend, to a large extent, on the types of resources available within the work organization and in the local community. Accordingly, it is important to evaluate these resources and design the program around them (so that critical missing resources can be identified and located).

The following organizational resources may need to be evaluated:

- Staff and budget commitments in human resources, medical, security, safety, and health benefits departments,with attention to the attitudes of staff in these departments toward drug abuse.

- An existing drug or alcohol abuse policy.
- Previous or current training programs about drug abuse for supervisors and workers.
- An EAP and its activities.
- An existing drug and/or alcohol testing program.
- Related substance abuse activities, such as workplace security efforts.
- Existing health insurance benefits for alcohol or drug abuse treatment. (Part of this analysis is to determine the coverage provided: Can outpatient services be paid for? Can inpatient services be funded more than once?)
- An existing physical facility to house the program that meets the needs for privacy, security for records storage, and other requirements.
- Self-identified recovering substance abusers in the work force who might be encouraged to provide support and volunteer services to the new program.
- An existing managed health care program.

Community resources that can be surveyed include the following:

- Community-based alcohol or drug abuse prevention and education partnerships or coalitions.
- Volunteer and self-help organizations (especially Alcoholics Anonymous, Narcotics Anonymous, and other 12-step programs).
- Consultants and consulting firms offering supervisory training, education and prevention programs, and other services, including EAP service providers.
- Related resources, such as a stress management program available through the local community mental health center.
- Local inpatient or outpatient chemical dependency programs (either freestanding or associated with hospitals or university medical centers).

These resources can be identified through several entities: local Chambers of Commerce or business and industry associations; local treatment facilities; State, city, or county alcohol or other drug abuse coordinating agencies; local chapters of EASNA, EAPA, or other professional and trade associations oriented to substance abuse services; or knowledgeable persons already employed in the workplace. Workplace Resources (following chapter 7) provides more information on these contact organizations.

To assess treatment resources, a workplace representative should conduct a telephone interview or site visit to verify the availability and quality of needed services. Ideally, a standard form or interview schedule should guide such information gathering. These data can be the beginning of the resource inventory a workplace substance abuse program needs for effective operation. This resource identification and inventory is analogous to the process by which companies develop specifications in preparing to seek bids for goods or services to be purchased, and approaches to conducting reference checks on quality, reliability, and other measures of satisfactory performance.

National Institute on Drug Abuse (NIDA) resources, such as the *EAP Training Curriculum* and the *Model EAP* document, provide useful background information for evaluating current resources and responses.

Strategic Planning Model

Once these preliminary activities have been completed, the organization can begin developing or enhancing a workplace program for alcohol and drug abuse, following these 10 steps, each representing a program component:

1. Set *organizational policy* on alcohol and drugs in the workplace.
2. Develop a written *program design* covering all aspects of program operations, staffing, and financing.
3. Develop *management and supervisor training* on alcohol and drug abuse.
4. Develop *identification and outreach* program components, including drug testing if appropriate.
5. Develop *workplace security* components.
6. Develop *assessment and referral* program components.
7. Develop *counseling and treatment* program components.
8. Develop *followup* program components.
9. Develop *recordkeeping and evaluation* program components.
10. Develop *prevention and employee/family education* program components.

Chapter 4 presents more details on each of these steps.

Developing the strategic plan may be the responsibility of top management, or it may come under a particular staff person (such as the EAP director), or it may be the activity of a special task force or committee within the organization. Such a committee will ideally include representatives of workers at all levels and any unions that may be involved. In responding to the initial data emerging from the three preliminary activities, the first question to be answered is: Is a new or revamped program needed? Only by honest evaluation of the needs, resources, and infrastructure of job performance appraisal can a reasoned decision be made about whether or not to move ahead with a substance abuse program.

The next step is to develop the strategic plan for the workplace program. The model presented in detail in the next chapter for developing such a plan is based on principles of strategic planning used widely in private industry, especially among larger companies. For those interested in reading more about the basic concepts of strategic planning, some reference works are listed in the Bibliography. (See the books by Argyris, Byars, Quinn, and Yavitz and Newman, for example.)

Typically, strategic planning begins with commitment from the organization's top management to an enhanced workplace alcohol and drug abuse program. Appointing an individual or committee to develop a written strategic plan based on this model comes next. Usually the plan will be developed by staff, although in some cases an outside consultant might be retained for this purpose. Management may assign a deadline for delivering the written plan and provide some general guidelines about its later implementation.

The strategic planning process may require weeks or months of activity to develop a set of organizational goals and proposed activities in each of the strategic plan's 10 content areas. The final strategic plan may be only several pages in length, or it may be an extensive report. It should cover issues such as whether all worksites and employees will be included

in the proposed program (a policy issue); whether drug testing of various types will be conducted; and how the substance abuse program will be integrated with the organization's existing programs and policies.

In general, a fair amount of detail without exhaustive background material will provide the most useful guidance for creating a program. For example, the strategic plan may outline the main components of an organizational alcohol and drug abuse policy without developing a full text of this policy. It may set goals and general procedures for supervisor training without detailing training content. Appendixes to the plan may provide more specific information if needed, or a separate implementation manual might be developed.

The strategic plan needs to include the time schedule for implementing the workplace program and should specify whether an incremental change approach will be used. If so, a rationale should be clearly stated for the order in which components will be initiated, how feedback from early implementation efforts will guide later activities, and what problems may be encountered in starting a program that is missing some key ingredients. For instance, if a drug testing effort is to be added in the second or third year of an evolving program, what steps can be taken to identify employees or applicants who use illicit drugs during the time testing will not be available?

As long as it is apparent that confidentiality will be maintained, those involved in the planning process can get valuable input from workers and supervisors, including information about current alcohol and drug abuse problems and other matters. Another valuable resource is other employers in the community who may be willing to share what they have accomplished in their own programs—their setup, their goals, their operation, and the degree of employer-employee satisfaction. Other issues may also be addressed in these interactions, such as the quality of certain treatment facilities and ways to convince top management that a program is needed.

While the report is still in draft form, it is critical to have relevant supervisory staff review the document. Concerned outsiders may also be consulted. For instance, review by a union official might be essential for later support in the event that management, for whatever reason, did not include union representation on the planning committee.

Review by an outside consultant or professional in the field of alcohol and drug abuse might also be of value. The report should be reviewed by representatives of all levels of workers in the organization to determine whether the general goals and procedures in the strategic plan are fair, technically correct, and feasible.

The organization's legal counsel must review the report during all phases of development. If possible, an outside legal expert with special knowledge in litigation and liability issues regarding workplace substance abuse should also be consulted. There have been many legal challenges to workplace alcohol and drug abuse policies and programs. As reported in case summaries from various newsletters and professional journals, arbitrators and courts generally find for the employer when a well-developed and well-communicated policy exists—another reason for management to develop a strategic planning group. The area under most contention is drug testing (see the section on drug testing in chapter 4), but virtually every aspect of a workplace program for alcohol and drug abuse should be subjected to careful legal review in order to limit organizational liability. In fact, there should be a process for ongoing legal review as the program develops.

Finally, the plan is presented to top management for approval and implementation (discussed in the next chapter). When the plan is announced to workers, the help of those

who participated in its development should be acknowledged. Mentioning individuals by name will build credibility for the program by letting workers know of the participation from their own ranks.

Conceptual Foresight

A good strategic plan has built-in components for conceptual foresight—that is, for anticipating possible deficiencies or problems in implementation, and planning in advance for their resolution. Many good programs fail because their designers did not anticipate anything going wrong; by the time the problems are evident, it may be too late!

Here are five questions about conceptual foresight that are especially important for developers of workplace alcohol and drug abuse programs.

1. Are there any deficiencies in available leadership resources? Does the plan have the support of the president, chief executive officer, or chair of the board? For example, are one or more top managers giving enthusiastic lip service to the program but expressing private doubts or hesitations? (On occasion, this situation may occur for a uniquely embarrassing—and most dangerous—reason: the executive is an abuser of alcohol or drugs! How to deal with such a delicate matter must be considered in advance, or the program—no matter how well designed—is likely to fail.)
2. Are there any deficiencies in available personnel or financial resources? Do key personnel have the skills, knowledge, and experience needed to implement a full-scale program plan? For example, despite adequate commitment of finances, could a downturn in company revenues or profits create a funding crisis? What would happen if certain key personnel left the organization?
3. Might there be a problem of overreaction—developing a program that is more intense than the organization's substance abuse problems really justify? An overly intensive program, especially one that is expensive or contains such controversial elements as random testing for illicit drug use, may quickly lose credibility.
4. Might there be a problem of overexpectation—promoting or viewing the program (on the part of management, workers, or the community) as a direct and immediate cure of all alcohol and drug abuse problems, or even of all problems of productivity and performance in the workplace? When this unrealistic dream does not come true, the good the program otherwise does may be ignored, and credibility can be permanently compromised.
5. Might there be a problem of overextension—setting goals for the program that are more ambitious than it can realistically accomplish? Again, quick loss of credibility can happen in such a case.

With all these potential problems, the key ingredient is advance planning. Start with the assumption that problems can and will arise, but that in-depth strategic planning can limit or even avoid negative consequences.

Interfacing With Other Organizational Programs

Substance abuse is a hard problem to tackle because it relates to so much else in the workplace. For this reason, and because many organizations already have begun interven-

tions that may help reduce the problems of alcohol and drug abuse, it is imperative that the designers of a workplace program determine early in the process how this program will interface with other organizational components.

The clearest example of such a component, of course, is an EAP. The EAP already has mechanisms for counseling, education and prevention, confidentiality, and other devices that are of enormous value for a budding substance abuse program. Thus, the strategic plan should embrace the EAP, not ignore or sidestep it.

Workplace alcohol and drug abuse programs also need to interface with the human resources or personnel departments of an organization. Many of the program's activities will be administered through human resources.

Health care and other benefits programs offer a natural tie-in for the alcohol and drug abuse program. In many cases, the single most important factor in determining a worker's ability to obtain the needed professional services is whether the worker will be covered by health insurance.

It has already been emphasized that the goal of any workplace substance abuse program is to help workers with problems get help (as well as to prevent abuse of alcohol and drugs through education, etc.). Companies vary enormously in the benefits they offer. However, an increasing number of organizations, including many of the larger corporations and public agencies, have workplace health promotion and wellness programs. These programs emphasize exercise, stress management, weight loss, and other elements that need to be integrated with an organization's substance abuse program. Research conducted by Terry Blum, Paul Roman, and Linda Patrick shows that there may be good synergism between EAP models and health promotion activities at the worksite.

Sometimes the nature of these interrelationships is fairly complex. For example, issues of confidentiality may have to be negotiated to permit a consultation about a given worker between the staffs of the substance abuse program and the company-run weight-loss program, even though addiction to diet pills can be a major problem. Similarly, including stress management training for ex-abusers may be a significant part of the rehabilitation process.

Company medical and security departments also need to be involved in developing a program for preventing alcohol and drug abuse. Both these departments can be excellent referral pathways for prevention information and early intervention. The credibility and potential for referrals stemming from interest in the program by the company medical director or security head may be quite substantial.

A company program should also be integrated with existing community substance abuse, mental health treatment, and rehabilitation programs. Other local resources, including self-help groups such as Alcoholics Anonymous, Al-Anon, and Narcotics Anonymous, can also be of tremendous assistance in treating alcohol and drug abusers and their family members and in helping workers remain alcohol- and drug-free after they have been through treatment.

Adapting This Model to Review Existing Programs

When used to evaluate or enhance an existing workplace substance abuse program, the strategic planning model presented here becomes a list of review questions. Have job performance standards been developed in a useful way for dealing with problems of alcohol

and drug abuse? Are they up to date? Are organizational patterns of alcohol and drug abuse changing? (Many workplaces find that the patterns of illicit drug use have changed substantially in the past few years, both at the worksite and in the local community.) Based on changing patterns of abuse, what corresponding changes in community resources have occurred? Which might be helpful to your workplace? How should the strategic plan be modified in light of these considerations?

A significant program review or enhancement, of course, can be almost as significant an organizational change as starting a program from scratch. Thus, strategic planning principles should also be used in designing and carrying out such an activity.

4. Implementing a Workplace Alcohol and Drug Abuse Program

Each organization using the strategic planning model presented in chapter 3 will implement it differently—because of differences in available resources, different types of incremental change desired, and other considerations. Therefore, no single template can be given. Some of the elements within each step will seem imprecise because precision has to come from applying basic concepts in a specific workplace environment. The purpose of this chapter is to provide a set of concepts and background resources to help employers design their own approach for each of the 10 steps. Additional resources may be found in the bibliography and appendixes.

The Overall Context

Like any other organizational change, a new (or enhanced) workplace program for dealing with alcohol and drug abuse is implemented in a complex, sometimes contradictory, context. Some of the factors that may need to be considered include the following:

- Integrating efforts to address alcohol and drug abuse problems into an existing (or developing) Employee Assistance Program (EAP) that may already attend to substance abuse and a variety of other workplace and personal employee issues.
- Integrating the program with the organization's overall activities regarding human resource development, and health promotion, safety, medical, and related concerns.
- Integrating the program with existing job performance standards, health benefit coverage, labor-management agreements, employee disciplinary policies, workplace security policies, etc.
- Addressing the program to other factors that might affect alcohol and drug abuse (such as self-medication for stress), for example, financial or management difficulties including downsizing of the organization.
- Addressing the program to factors common to the industry of which the particular workplace is a part, for example, working conditions that appear to produce greater likelihood of alcohol or drug abuse in industries such as entertainment and recreation, athletics, construction, and food services. (See figure 5.)
- Addressing the program to local community attitudes and activities relating to alcohol and drug abuse (e.g., does the workplace exist in a community known to have serious

substance abuse problems, or comprehensive prevention and/or treatment programs?).

- Planning a comprehensive prevention effort for employees and their families.

In fact, all the special issues cited in chapter 6 constitute contextual issues to which program planners must respond, either by deciding they are not relevant (or at least not addressable), or by determining how to respond to them. Contextual factors work both ways. For instance, a company working to establish an alcohol and drug abuse prevention program might also consider how this activity could strengthen efforts to provide stress management training for employees (and so reduce self-medication for stress and other purposes).

Implementing the 10 Steps of the Strategic Planning Model

Step 1. Organizational Policy

A written policy statement should be prepared and distributed to all workers. The policy should specify the organization's philosophy and practice with regard to employees who abuse alcohol and drugs, as well as the disciplinary consequences of such abuse. As such, it provides guidelines to management and supervisory personnel for handling employees suspected of abusing alcohol or drugs. In addition, it can be used to inform all employees about the organization's position on substance abuse and provisions for assisting employees with abuse problems.

It may be valuable to read the policy statements of other organizations and to consult with those responsible for creating policy guidelines to determine why certain issues were covered, to determine how the policy was reviewed and revised in draft form before finalization, and to explore related issues. In chapter 2, information regarding policy development from the National Institute on Drug Abuse's (NIDA) Policy Models study was provided. The study reviewed workplace policies regarding substance abuse that are found primarily in medium to large employment settings.

Content. According to the study, when developing a comprehensive policy statement, issues that need to be addressed include the following:

- The organization's overall position on alcohol and drug abuse (e.g., substance abuse is a medical problem, but it is unacceptable in the workplace).
- The organization's position on consequences for employees using, selling, or possessing alcohol or drugs in the workplace (discipline, termination, due process, etc.).
- The organization's position on job performance as it relates to alcohol and drug abuse.
- The organization's position on safety of the public and coworkers as related to substance abuse.
- The organization's position on treatment and aftercare services available to employees (or their family members) who have alcohol or drug problems.
- The responsibility of the employee to seek treatment and issues surrounding the employee's return to duty.

- The observance of strict confidentiality for employees who are in treatment and procedures for dealing with any violation of confidentiality.
- The organization's position on drug and/or alcohol testing.

Review of Policy. A policy statement should be drafted by management, union representatives, and workers representing all levels of the company. Active cooperation with any labor unions involved is essential, since the policy will almost surely touch on issues governed by union contracts. Human resources, health benefits, security, and other involved departments must be allowed to review the policy for impact on their operations. Staff involved in long-range planning for human resources of the organization need to appraise the policy for its impact on the workplace as a whole. Legal experts must review the document because policies related to drug testing, treatment, confidentiality of records, and so forth are increasingly the subject of litigation.

If an EAP exists in the organization, it is essential that EAP staff be involved in drafting and reviewing the policy statement, even if the EAP will not be solely responsible for implementing it. Because of the EAP's role in referral, crisis intervention, training, and other activities, EAP support will be critical to the success of any alcohol and drug abuse policy.

Communication of Policy. A written policy statement made available to all employees can serve as an effective introduction to a substance abuse program. Organizations often overlook the importance of communicating a newly completed policy by issuing a special memorandum from the chief executive officer announcing it or by holding a meeting of all employees to discuss how the policy will be implemented. The program can also be publicized through supplemental communications such as pay envelope stuffers and mailings to employees' homes. Information posted on bulletin boards or placed in the workplace newsletter can also help.

An initial orientation session at which workers gather with top management serves an important function in confirming that the organization's leadership firmly supports the program. Ultimately, however, once the program has established a solid reputation, the most effective publicity may come from word of mouth among employees.

In some cases, formulating a written policy may toughen or make more specific a stance the organization has long taken. Sometimes the policy statement may be used to give a 30- or 60-day advance warning that new procedures will be instituted, such as drug testing, suspension, or firing under certain circumstances.

Program publicity can include a statement of the organization's policy on abuse of alcohol and drugs, a description of the services offered under the program, and information on how to contact program staff. Confidentiality should be stressed.

The reader is encouraged to contact the CSAP National Workplace Helpline (see Workplace Resources following chapter 7) for a wide spectrum of information useful in policy development, including sample policies.

Step 2. Program Design

A written program design for operating, staffing, financing, and evaluating the workplace alcohol and drug abuse program is essential for effective operations. Although such a plan may be brief, it should specify how the program will operate; the reporting structure within

the organization; provisions for regular review of policy, procedures, and outcomes; and mechanisms for improving the program over time.

Ideally, a program design should begin with the organization's written substance abuse policy, plus any preamble management wishes to supply about the importance of the program. The program design should then discuss each of the eight remaining steps in the strategic plan, presenting sufficient information to indicate how the organization will address each area.

As with the policy, the draft of the program design should be reviewed by as many levels of personnel within the organization as possible, ideally through a task force or employee committee. Reviewing the draft program design with other local employers who have already implemented programs for alcohol and drug abuse may also be quite valuable.

Step 3. Management and Supervisor Training

Front-line supervisors, managers, and senior executives may need training about a number of substance abuse issues. Most newly developed programs benefit from a training needs assessment, which should be done as soon as possible after the program design has been approved. Supervisors and managers may need training in some of the following areas:

- How to detect, and detect early on, deteriorating performance that may be related to illicit drug use. (While it is not the purpose of any substance abuse program to make supervisors into detectives or diagnosticians, some knowledge of the warning signs of alcohol or drug abuse—both physical and psychological symptoms—may alert supervisors to employees whose performance may need closer watching.)
- The physiological and psychological aspects of alcohol and drug abuse and addiction, with specific details about major illicit drugs such as marijuana, cocaine, and amphetamines.
- Special issues surrounding abuse of alcohol or drugs in the workplace such as drug testing, safety, and drug trafficking.
- How to implement their employer's alcohol and drug abuse prevention policy and related guidance for policy implementation.
- How the substance abuse program relates to other EAP activities, insurance coverage, health care cost containment, and other issues in the human resources area.

Education may take several forms, including seminars, films and videotapes, lectures, or printed materials. The Workplace Resources section following chapter 7 lists numerous potential training resources. The education sessions may be conducted by the program coordinator, outside consultants, or other personnel associated with the program.

Special Training for Senior Executives. Upper management personnel may need specialized training in developing workplace policies and programs, delegating such responsibilities to planning committees (and devising other strategies to involve employees), and communicating the work organization's philosophy about alcohol and drug abuse to lower level managers and supervisors, the work force at large, families of workers, the community, and the mass media.

Training sessions for senior executives can include information about national government and employer policies on alcohol and drug abuse issues, results of public opinion polls,

and ways in which corporate philosophies can best be presented to the audiences mentioned above. If the organization has evaluated an existing workplace substance abuse program, results from that evaluation can be presented to senior management, along with interpretations of the results in organizational performance and human terms.

Keeping abreast of national trends in the alcohol and drug abuse field and current best practice in a given industry can help senior executives assume leadership positions in their own workplace. Finally, it may also be appropriate for top managers to receive awareness training about abuse of alcohol and drugs in their own ranks. Such training may help some to refer themselves for program services and others to identify executive performance problems that can lead to management referrals.

Special Training for Front-Line Supervisors and Union Representatives. Front-line supervisors, because of their central role in the referral process, can benefit from general education about substance abuse, as well as special training and program goals. That is also true for union representatives who may be involved in the referral process. Training should focus on the functions of the supervisor in the referral process: observing and documenting unsatisfactory job performance, notifying employees when their job performance is unacceptable (i.e., using constructive confrontation), referring an employee to the program, or encouraging employees already receiving EAP services. Special training about the supervisor's role with regard to drug testing and mandatory referral to treatment may be needed.

Care should also be taken to teach supervisors what they should not do. They are not substance abuse professionals and should not try to either diagnose or treat possible alcohol or drug problems among their workers.

Step 4. Identification and Outreach

Identification: Getting the Referrals. Workers are referred to alcohol and drug abuse programs in the following five principal ways:

- Self-referral.
- Supervisory referral (including both voluntary referrals and those involving constructive confrontation or disciplinary action; it may also include referrals made by medical or human resources department staff, as well as referrals by the worker's direct supervisor).
- Drug testing referral.
- Family referral (a referral by a family member; today, even a minor child may confront the worker with a suspected substance abuse problem and encourage treatment).
- Peer referral (a referral by a coworker).

When the referral is to some extent involuntary, both those making the referral and the program personnel receiving the individual must be prepared for hostility and suspicion about the substance abuse program. Even with voluntary referrals, denial may still be strong enough to prevent a clear statement about the nature and extent of alcohol or drug abuse.

While detecting impaired job performance is the single most frequent reason for a supervisor to make a referral, early detection is often possible through the observation of obviously impaired behavior on the job or in social situations. The role of the supervisor is not to judge whether a problem exists, but only to refer the person to a trained professional for that determination.

Once the employee has been connected with the program, the relationship between the worker's supervisor and the program becomes sensitive. If the referral was initiated by the supervisor, the program is usually required to report progress, but this report may be a simple statement that the worker has kept appointments or that satisfactory progress is being made. In some instances, direct consultation with the supervisor may be helpful, provided the worker gives permission in the form of written consent.

Employee self-referrals are likely to increase as the program gains credibility and employees develop confidence in it. Self-referrals can be encouraged by guaranteeing confidentiality to those who contact the program and by providing a special office or telephone number where employees can reach a program staff member. Accepting anonymous telephone contacts also increases self-referrals, since such contacts allow reluctant employees to gradually gain confidence in the program.

When the work force is represented by labor unions, it may be possible to integrate procedures for identification and referral into a joint labor-management agreement. Many union contracts are now written so that employees who decline referral to an EAP after well-documented evidence of performance problems may be dismissed without union protest.

Drug Testing. Drug testing is one of the many tools available to reduce illicit drug use in the workplace. Companies may use drug testing to send a strong message to applicants, employees, and supervisors that illicit drug use in the workplace will not be tolerated. The work atmosphere created by this message may actually encourage non-drug-using employees to remain drug free and encourage occasional users to stop. Drug testing in this capacity may actually achieve a deterrent effect.

A drug-free message is further emphasized if employees with illicit drug problems are offered help through an EAP, and if applicants who test positive are given information for referral to local treatment programs and told that they may be considered again for employment after a period of time, as set out in the company policy. In this publication, drug testing is viewed as one component of a comprehensive workplace substance abuse program.

Incidence and Results of Drug Testing. A number of studies have recently explored the incidence and types of drug testing programs in workplaces. The 1988 and 1990 Bureau of Labor Statistics (BLS) studies were discussed in chapter 2. The overall finding from these studies is that the number of drug testing programs in American workplaces is increasing. In the 1988 study, it was found that business establishments in mining, communications, public utilities, and transportation are most likely to have drug testing. Establishments least likely to have such a program are in retail trade, repair services, and construction. Drug testing was not found to vary appreciably by geographical region. Of the establishments engaged in drug testing, 85 percent had a program to test job applicants, while 64 percent had a program to test current employees.

In a recent study conducted by the American Management Association (AMA), 63 percent of 1,663 respondents had a testing program, a 200-percent increase over a 1987 AMA study. The AMA attributes the increase in testing to new Department of Transportation regulations and a greater acceptance of testing as a result of favorable court rulings protecting employers. In the study, 54.4 percent of employers tested newly hired employees and 49 percent tested current employees under "for cause" conditions.

The Conference Board conducted a study of drug testing in 1988, reported by its investigator Helen Axel in 1989 and in two 1990 Conference Board reports. Larger business establishments were found to be more likely to have drug testing programs, a consistent finding among many drug testing studies. Forty-three percent of establishments with 1,000 or more employees practiced drug testing, while only 2 percent of those with 50 or fewer employees had such a program.

Drug testing programs were found to be most common in manufacturing and utility industries, while they were less common in the financial services sector, such as banking and insurance firms. Executives who began drug testing programs in their organizations reported that evidence of drug problems at work was the single most important reason such a program was started. Drug testing firms were also found to be involved in other substance abuse control strategies, such as establishing a written policy on alcohol and drug abuse and offering EAP services. A complete description of the Conference Board's findings is contained in the 1990 report, *Corporate Experiences with Drug Testing Programs*. A companion document, *Substance Abuse and Drug Testing*, features the abuse policies and guidelines of 12 large firms.

With regard to the incidence of positive test results, SmithKline Beecham Clinical Laboratories reported 1994 results based on their overall test results of workers and job applicants.

- 8.4 percent tested positive in 1993, down from 18.1 percent in 1987.
- Rates of positive drug tests have leveled off at about 8.5 percent for the past 3 years (8.8 percent in 1991, 8.7 percent in 1992).
- The most common illicit drug for which positive test results were obtained was marijuana, followed by cocaine.

The Department of Transportation (DOT) conducted a 1990 drug testing study in which 95 percent of the respondents were Federal Aviation Administration employees. This study showed a 0.47 percent rate of positive test results in the first half of 1990, a much lower rate than observed for other safety-sensitive jobs in transportation (as in the study reported above). Such a finding may mean that the DOT testing program is indeed an effective deterrent.

Despite the growing number of firms with drug testing activities, many States have passed laws restricting the types of tests employers can perform. In Connecticut, for instance, the State legislature permits preemployment and reasonable suspicion testing, but random testing is allowed only under certain circumstances.

Passage of the Americans with Disabilities Act in July 1990 offers limited protection for workers using illicit drugs. Under the terms of the act, employees can be disciplined or fired if they are shown to be "current users," but functional standards for this term have yet to be defined. Exemptions can be made if employees can demonstrate that they are in a rehabili-

tation program, but the standards for evaluating such demonstrations are still vague. Inevitably, these aspects of the act will result in legal challenges.

Support for drug testing among employees themselves appears to be increasing. The Institute for a Drug-Free Workplace's 1989 employee survey found that virtually all respondents (97 percent) favored drug testing, at least under certain circumstances or conditions. Eighty-six percent felt drug testing was a good idea for employees in the following occupations: airline pilots, workers in safety-sensitive jobs, transportation workers, truck drivers, and health care workers. (It should be noted that not all surveys of worker attitudes on drug testing report such favorable attitudes.)

Methods of Testing. Briefly, drug testing typically involves analyzing a urine sample to determine whether the person has recently used drugs (blood, breath, saliva, or hair follicles are also sometimes tested). A number of testing procedures are currently used, some of which are extremely accurate. However, all viable programs involve two-stage testing for any sample on which the initial test is positive, usually with a different type of test. A legal procedure called a chain of custody is used to protect the integrity of the sample by documenting each and every person who handles the specimen, from its origin through all phases of testing. Urine testing shows whether a person has used drugs in the recent past. It does not prove intoxication or impaired performance (a worker could test positive from drug use that occurred away from the workplace, with no evident impairment of job performance).

Purposes for Testing. The Department of Health and Human Services defines the following six major types of drug testing:

- Applicant testing—to screen out job applicants who are using illicit drugs prior to being hired.
- Reasonable suspicion testing—to respond to documentable facts and circumstances leading to suspicion of illicit drug use, in order to protect the safety of coworkers and provide the suspected employee an opportunity for rehabilitation in the case of a positive test result.
- Accident and unsafe practice testing—to provide a safe and secure work environment by having the option to test any employee who is involved in an on-the-job accident or who performs any job function in an unsafe manner.
- Voluntary testing—to provide employees an opportunity to demonstrate their commitment to the goal of a drug-free workplace in their work setting and to set an example for other employees.
- Treatment followup testing—to ensure that employees have not relapsed during or after treatment.
- Random testing—to reduce specific risks involved with illicit drug use by employees in designated positions.

Whatever the reasons or justifications for instituting random or universal testing of employees, testing arouses the most controversy of all the issues related to alcohol and drug abuse in the workplace. Instructive guidelines to help employers decide whether a testing program is right for their workplace have been suggested by David Evans, an attorney with practical knowledge of current legal issues. In his article in *The ALMACAN* (see Bibliography), he briefly discusses several considerations in formulating a policy on drug testing:

- Document the need for a testing program. Is it necessary for complying with regulatory mandates, enforcing work performance standards, detecting illegal drug possession, appraising candidates for employment, monitoring the EAP, or determining the cause of onsite incidents?
- Develop a testing policy. Taking into consideration union, management, personnel, occupational health and safety, affirmative action, risk management, security, legal, and EAP issues, develop a testing policy that addresses the following concerns:
  - Need for the policy.
  - Use of alcohol or drugs on company premises, on or off duty.
  - Need for companywide awareness of work performance standards.
  - Possible consequences of positive test results as they relate to discharge, discipline, or other sanctions.
  - Due process procedures for employees who test positive.
  - Procedures for confirming positive test results.
  - Rehabilitation opportunities if an employee tests positive.
  - Need for compliance with State and Federal discrimination laws.
  - Procedures for referral to the EAP.
  - Responsibility of employees to seek treatment.
  - Confidentiality of test results and treatment.
  - Circumstances in which testing will be required.
  - Consequences of refusal to take required drug tests.
  - Company procedures for fair and dignified testing procedures.
  - Types of drugs the tests will detect.
- Implement the drug testing program based on this policy. More information on implementation is provided in the next section.
- Implement the policy and program. All supervisors, employees, and job applicants should be informed in writing of the details of the policy and the program that will implement it. Training should be provided on job performance standards and the operation of the testing program and its relationship to other services (e.g., those offered through the company EAP).

Modifications in collective bargaining agreements may also be needed to successfully implement a testing policy or program. A procedures manual should be developed for testing, including the chain of custody. Finally, an outside consultant should evaluate the program periodically in collaboration with a program improvement committee composed of the organization's legal counsel and workers at all relevant levels.

Legal consultation is especially important, because employers have to contend with an increasing number of issues related to testing. Employers with drug testing programs are being sued, and those with clearly defined programs are, all other things being equal, best able to defend themselves successfully against legal action.

Among the key litigation issues are invasion of privacy, wrongful discharge, defamation, intentional infliction of emotional distress, employer negligence, assault and battery, false imprisonment, and discrimination against minorities or persons with disabilities.

Employers considering a drug testing program may want to visit a nearby workplace that has already made a similar effort, to learn not only about program design but also about implementation problems and any real or threatened legal challenges. Also, model programs and policies are now being documented in the literature (see Bibliography).

Outreach. Outreach programs can take advantage of the workplace's entire communication structure. Pay envelope flyers, bulletin board notices, brown-bag lunch lectures, speeches at organization-wide gatherings, notices or articles in a company newsletter, and many other devices have been used. In some cases, a work organization's audiovisual department has put together a slide show or videotape presenting the program. In others, workers recovering from alcohol or other drug abuse are recruited to talk to their fellow workers. Videotapes and print materials for this purpose are available from the National Clearinghouse for Alcohol and Drug Information (NCADI) and from a number of other resources, as presented in the Workplace Resources section following chapter 7.

Considerable ingenuity can be used in these outreach approaches. For example, it has been found that brown-bag lunch seminars with such titles as "How to tell if your kid is using alcohol or drugs" draw large audiences—always including some workers who are there to learn something about their own alcohol or drug problem, not their children's. These outreach programs can usually be designed to help build the program's overall credibility with workers.

Step 5. Work Force Security

A workplace's physical plant security operations become involved with worker substance abuse in some of the following ways:

- Stopping the sale of alcohol and drugs in the workplace.
- Detecting the presence of illicit drugs in the workplace.
- Dealing with workers who use alcohol or drugs on the job and whose performance is impaired.
- Dealing with substance-abuse-related behavior (e.g., stealing from other workers to buy alcohol or drugs).
- Dealing with issues related to confidentiality of information or products of the workplace (e.g., an aerospace company doing business with the military).

In their efforts to deal with alcohol and drugs in the workplace, organizations are increasingly using their own security forces and consultants from the outside, including drug-sniffing dogs and high-technology devices to detect the presence of drugs or provide surveillance of areas in which drug sales may take place. In some cases, collaboration with local, State, or Federal law enforcement agencies may also be desirable. A careful preliminary investigation should be done before bringing in outside law enforcement. Some local law enforcement agencies simply are not equipped to handle a sophisticated undercover investigation. However, large agencies may not want to get involved in what they see as small-scale illicit drug operations in a workplace.

Drug testing programs may sometimes connect with security efforts, as in required testing for workers who are brought under suspicion by inside or outside investigations. The entire workplace substance abuse program or EAP must be carefully coordinated with security

operations. It is essential that the two operations remain functionally independent, because any substance abuse treatment or prevention effort will instantly lose all credibility if it is seen as having an investigative or enforcement function. However, certain kinds of cooperation and information sharing may be possible. For example, security personnel may see evidence of alcohol or drug abuse that can be handled discreetly by helping workers enter treatment.

Step 6. Assessment and Referral to Treatment

Assessment. When a worker enters an EAP, an initial assessment determines what services may be needed. Most professionals find it helpful to use a structured interview form, including questions about life history, previous treatment, history of alcohol or drug abuse, self-appraisal of performance impairment, and other issues. Careful recordkeeping can facilitate better service down the line, especially if the program will be involved in providing initial counseling or followup assistance. In a crisis situation, of course, routine assessment may have to be deferred; even so, situations of drug overdose, suicide attempts, or medical emergencies precipitated by illicit drug use (e.g., a heart attack) require good assessment and recordkeeping after the crisis has been resolved.

In the initial assessment interview, it is important to stress confidentiality and to help the worker understand the philosophy and services of the program. Self-referred workers, in particular, may simply not come back unless their first experience is positive and they feel that their confidentiality has been assured.

Referral to Treatment. The next step is to develop a treatment plan that will meet the needs identified in the assessment. The services most likely to be rendered in the workplace are crisis intervention or short-term counseling for problems that can be resolved in one to five sessions. For example, a worker who is having trouble withdrawing from sleeping pills (prescribed by a physician who is also monitoring medication usage) after a traumatic divorce needs support, but may be able to resolve the problem through a few sessions with an in-house counselor combined with medical support from his or her physician.

The treatment plan often involves referral to an outside treatment facility as well. This step requires an EAP counselor or other helping professional based in the workplace to be sensitive both to the special needs and circumstances of the employee and to the nature of the resources available in the community. Making a good match between the individual and the treatment facility is critical to successful recovery; treatment philosophies, geographic location, and many other factors may be relevant to the matching process.

Typically, the best way to become familiar with community resources is to arrange site visits. When setting up a workplace substance abuse program, such site visits will require a regular commitment of time during the program's first 3 months of operations, and time should be budgeted accordingly. When evaluating a facility, questions such as the following should be asked.

- Who provides diagnosis, treatment, and supervision, and what are their professional qualifications?
- What drugs of abuse does the facility claim competence in treating, and how does the program determine successful outcomes?

- What special competence does the facility have in treating alcohol and other drug abusers who may also have psychological disturbances, family problems, etc.?
- What treatment model does it use, and what specific treatment is provided?
- To what extent are self-help groups and the Alcoholics Anonymous model a part of the treatment philosophy?
- What is the facility's reputation in the community?
- To what extent does it serve employers well?
- What kinds of accreditation or certification does it have?
- What is its fee structure and to what extent can this be adjusted for special needs?
- How does the facility appear during an unannounced visit, as opposed to when taking a scheduled tour?
- What special populations does the facility serve?
- How long does the program last, and is any aftercare or followup provided?

NCADI's resources on model EAPs and workplace substance abuse programs may be helpful in dealing with the above issues (see Workplace Resources for more details).

One of the most valuable tools any program coordinator will generate is a file of local treatment facilities with the answers to such questions. Program staff need to be familiar with these programs to identify the one that is right for an individual worker. Knowing, for example, that a particular facility would be appropriate for a blue collar production worker, but not for a senior executive, can help avoid inappropriate referrals. Special circumstances also might affect the referral. For example, does the worker have small children who need care? What type of insurance coverage is available? Often, insurance provides only for inpatient care, even though the person may need extended outpatient care. In such cases, negotiation may be needed to determine what the workplace can provide and what the person can afford to pay out of pocket.

Step 7. Counseling and Treatment

With rare exceptions, work organizations do not directly provide the intensive counseling and treatment services needed by employees with alcohol or drug abuse problems. Crisis intervention services and short-term counseling may be provided on occasion by EAP professionals, company medical directors, or consulting mental health professionals, but treatment services will be provided primarily by substance abuse facilities in the community. Both inpatient and outpatient facilities are needed to provide a full array of treatment options.

In addition to treatment facilities, many other local resources will help build a complete intervention, treatment, and rehabilitation program: self-help groups such as Alcoholics Anonymous and similar programs, family support groups, school alcohol and drug abuse education projects, local mental health centers or hospitals, and training provided by local schools or television stations.

Step 8. Followup

Even the most successful treatment programs have high recidivism rates. Alcohol and drug dependence or abuse is a chronic relapsing and recurring illness that may continue for years. As a rule, long-term treatment and followup services are needed. This fact has important implications for both the workplace program and the treatment services that take its referrals. Components of a workplace followup program may include the following:

- Providing case management to monitor and evaluate the help the worker is receiving from a treatment program. For example, the program might offer counseling and group support that fit with the individual worker's situation.
- Appraising the work environment to which the worker returns after treatment. At present, many employers are examining the workplace with hopes of reducing job stress and improving overall work conditions as a means of preventing rehabilitated workers from returning to alcohol or drug abuse and, more importantly, helping to prevent substance abuse in the first place. Program coordinators may need to assess levels of job stress and consult with supervisors or top management to effect changes in the work environment.
- Developing followup support services, such as Alcoholics Anonymous or other self-help group meetings held at the worksite.
- Reviewing organizational insurance coverage to determine whether appropriate followup services are eligible for coverage. For example, many policies do not cover outpatient services, even when this may be the most appropriate approach to treatment (and more cost-effective than repeated inpatient hospitalizations).
- Reviewing treatment facilities to determine which ones address the problem of recidivism most creatively and effectively. What resources and programs are utilized to help prevent the person from relapsing? What is done to help if relapse occurs? For example, some facilities may offer a guarantee of additional treatment without charge for those who were rehabilitated but return to abusing alcohol or other drugs within a certain period after leaving their program.

Step 9. Recordkeeping and Evaluation

Recordkeeping. As with any worker service program, an information system must permit good referrals to appropriate community resources, with a parallel recordkeeping system for services provided. Increasingly, in large programs these systems are computerized. For example, many employers today maintain all program data on computer, printing monthly reports (clients are not identified in these records). Comparisons of costs and outcomes by month or year are easier to prepare with such a system.

Data on program costs, number of contacts, source of referrals, case dispositions, and the impact of interventions on employee absenteeism, sick leave insurance claims, and disciplinary actions will prove useful in evaluation efforts. Information on employee background, referral source, and stated purpose of contact can be gathered during the initial interviews. Other information on case disposition and job performance during and after contact can routinely be entered in case records. Personnel records of the organization may be consulted to gather information on job performance evaluations.

All case records must be kept absolutely confidential and located in a place where only a program coordinator or counselor has access to them. When data from case records are used for evaluation purposes, they should be presented in the aggregate, with no chance for individual client names to be linked to specific case information.

Performance and evaluation data can also be important in the event of labor actions surrounding a particular employee or legal actions in which the employer is involved.

Evaluation. Program evaluation is an integral part of a workplace substance abuse program, in terms of both administrative accountability and successful program operation. Evaluating program outcomes can yield information on the effectiveness of a program and point out its particular strengths and weaknesses.

However, depending upon the complexity of the evaluation, it may be necessary to have outside staff trained in conducting such studies work with program staff in the evaluation. Special skills may be needed to design an appropriate study methodology, to collect the data systematically, and to complete the analyses. Program staff frequently lack training in conducting complex evaluations. Use of outside evaluators also reduces the potential for conflict of interest—an inherent problem in allowing program staff to evaluate their own program!

Program evaluation serves two major purposes. First, a good evaluation will provide information on the types of alcohol and drug abuse problems among the employee population, which may then guide program development. Second, evaluation can provide feedback for program improvement to staff and management. Of course, the larger purpose of feedback to management is to ensure appropriate continuation of the program: only those programs that demonstrate a positive impact on reducing costs of alcohol and drug abuse and increasing organizational productivity are likely to survive.

One useful evaluation approach is to compare various measures of employee job performance before program contact and after. A sustained evaluation process, perhaps on a regular basis at the beginning, can help in program development. Regular review, perhaps annually, by an outside evaluation consultant or by an in-house advisory body, may also be useful.

Step 10. Prevention and Employee and Family Education

Prevention. The ultimate solution to alcohol and drug abuse is preventing its occurrence. Ideally, prevention activities should be integrated with community-based prevention organizations and treatment programs so that all can work synergistically.

As with many other problem areas (e.g., smoking), the key to effective prevention is to change people's attitudes and beliefs so they can change their behavior and to reinforce their auto-abuse beliefs and behaviors. The workplace is surely one of the best environments for undertaking prevention activities. Most early prevention programs were designed to give facts about abuse of alcohol and drugs. Many concentrated on scare tactics; however, such efforts are largely ineffective. Workplace substance abuse programs must concentrate their prevention efforts in more productive areas, such as identifying coworkers who can serve as role models, providing incentives for participating in various anti-alcohol and drug abuse activities, and creating a working environment in which abuse of alcohol and drugs is not tolerated.

Research studies have shown that training in assertiveness and social and communication skills have helped young people resist peer pressure to smoke. Encouraging young people to assert their right to say "no" to illicit drugs, drinking, or smoking makes an effective prevention program. Similar efforts to reinforce attitudes, beliefs, and behavior against alcohol- and drug-abusing lifestyles can be developed for the workplace, using a variety of motivational messages, images, and approaches.

Prevention education programs, especially those utilizing the mass media, have become common in recent years and often have some sort of tie-in to the workplace. For instance, the Partnership for a Drug-Free America continues successful campaigns through TV advertisements and print advertisements placed in the *Wall Street Journal* and other business periodicals.

Companies may want to review other successful prevention activities (e.g., reducing accidents and helping people to stop smoking). Other current prevention activities might also be examined for possible integration with the substance abuse program (e.g., a company health promotion program).

Prevention efforts may entail encouraging special efforts to reduce stress—in the workplace or in workers' personal lives—or to provide training in stress management techniques. These interventions prevent alcohol and drug abuse by reducing the motivation to take alcohol or drugs as self-medication for stress. Strong linkages between a workplace health promotion program and a substance abuse program also can be helpful.

Ultimately, a prevention program seeks to improve not only individual worker behavior, attitudes, and beliefs, but also the organizational culture as a whole. As long as the set of common values, attitudes, and assumptions about life in the workplace encourages or tolerates abuse of alcohol and drugs, such abuse will continue. A long-range goal of any workplace substance abuse program is to create a social environment where such abuse simply is not allowed, by common consent of all who work there.

Employee and Family Education. Providing information to employees and their family members about the signs and symptoms of alcohol and drug abuse and about methods for treatment and rehabilitation can be a valuable component of a prevention program. For example, people sometimes get addicted to prescription drugs because they genuinely believe they cannot become dependent on something their doctor prescribes for them. Sometimes they do not realize the powerful effect of alcohol combined with tranquilizers or other drugs. Others may still believe certain myths that stubbornly refuse to die, such as those about casual illicit drug use being completely safe.

Educational seminars for spouses and children of workers can be just as valuable, both in transmitting needed information and in creating an atmosphere that is less tolerant of alcohol and drug abuse. Some employers have mailed newsletters or other materials to workers' homes that have been specially designed for reading by the whole family, not just the worker.

Organizational events such as workplace health fairs can also have an impact on family members as well as workers. Family members can be encouraged to attend, and special events can be designed for spouses or children. Activities of this sort may also be included as part of other health promotion activities such as fun runs and walks, which are becoming increasingly common in both public and private workplaces.

Program Administration and Staffing

Staffs for workplace programs tend to be small, even when serving very large organizations. The typical program in a medium-size or large organization is likely to consist of a program director, an administrative assistant, and one or two EAP counselors. However, these full-time staff are often supplemented by human service professionals working on a contract basis, especially if the program is providing clinical services to a large number of employees in many different locations.

Outside Consultants

All the standard organizational guidelines about identifying, evaluating, and choosing a consulting or training service apply to those employers choosing to operate a program with outside consultants or consulting firms. Consultants and consulting firms in the employee assistance or substance abuse field abound, but the quality of these practitioners varies. The questions to ask when selecting a consultant include the following:

- What is the consultant's track record in working with troubled employees?
- What track record does the consultant have with organizations in the employer's community or industry?
- What is the consultant's specific track record with alcohol or drug abuse? Some consultants from a mental health or alcoholism services background may know little about illicit drugs such as cocaine.
- What level of detail about operations and success rates is the consultant prepared to share in advance? One sign of a poor choice is the consultant's inability to talk about the specifics of program design or silence about success rates with other clients.
- What do other satisfied clients of the consultant have to say? Another sign of a suspect consultant is unwillingness to provide referrals to other clients.
- What will the services cost, and specifically, what is provided for the costs incurred?

Staffing

In the past, the staffs of many treatment programs and workplace alcohol and drug abuse programs, including a number of program heads, were recovering substance abusers. As the alcohol and drug treatment field has expanded, this situation has changed somewhat, and fewer staff members now have this background. At present, many major universities offer training programs for employee assistance counseling, and an increasing number of professionals from various academic backgrounds are selecting this field as their first career choice.

Moreover, certification programs exist for personnel in the fields of alcohol and drug abuse treatment and employee assistance. The Employee Assistance Professional Association (EAPA) has been operating a national program to certify employee assistance professionals for eight years, and the American Society for Addiction Medicine (ASAM) has a similar program for physicians. Each State has its own certification standards and licensing boards for different clinical professions, such as social workers and psychologists. There is a National Commission for the Accreditation of Alcoholism and Drug Abuse Programs. Other organizations supporting sound certification standards include the National Association of Alcoholism and Drug Abuse Counselors and the Certification Reciprocity Consor-

tium, which works to facilitate transfer of certification when counselors relocate in other States. Certain States—California, Florida, and Tennessee, for example—have passed legislation that provides standards for EAPs.

The recovering person has a unique perspective and often can see beyond the denial, defense mechanisms, and manipulative behavior exhibited by an addict that may be difficult for a nonrecovering person to detect. At the same time, ex-abusers do not automatically have knowledge about treatment methods, program administration, and all substances of abuse. This knowledge requires professional training and may be important to program success. Mental health knowledge and training are also important, especially for dealing with other serious individual, family, and emotional problems that employees may be facing and for differentiating which problems are related to alcohol and drug abuse and which are not.

Placement of Program in the Organizational Structure

The administrative placement of a workplace alcohol and drug abuse program relates not only to the management of organizational operations, but also to program effectiveness. In general, effectiveness is heightened if the program is regarded as a professional service made available to all employees.

Administrative accountability should be restricted to aspects external to the actual provision of services. For example, operating expenses and information on case outcomes should be reported, whereas confidential details related to the treatment itself should not be reported. Coordination with other departments on matters such as health insurance coverage is also necessary. However, independence helps to promote the confidentiality of the program.

The most common placement of information, referral, and crisis intervention program components is within an existing EAP. Other choices are the workplace's human resources department, medical department, or special placement in the office of the chief executive officer. Except under unusual circumstances, placement within company security or safety departments would be inadvisable because of the regulatory purposes these units serve. Careful choices must also be made about where to place a drug testing program—it is usually separated from the EAP.

5. Examples of the Strategic Planning and Incremental Change Approaches

This chapter presents brief descriptions of five applications of the strategic planning and incremental change methods presented in this publication. Each of these cases highlights how leadership and resource commitments assisted in promoting success. One example has been chosen for each of the five critical elements of a comprehensive design to make the workplace free of alcohol and drugs—employer policy, supervisor training, employee education, Employee Assistance Program (EAP), and drug testing.

Example 1. Employer Policy

The Champion Paper Company launched its alcohol- and drug-free workplace policy in 1987, following an extensive period of preparation. The preparatory effort included significant research about what dimensions needed to be covered by the policy and how best to implement the program. Critical to the success of this developmental effort were the efforts of an advisory council that surveyed how other work organizations had developed and implemented their own policies in this area. From this analysis, a series of "do's" and "don'ts" was identified, highlighting some of the most common pitfalls in policy implementation.

Champion learned, for example, that policies implemented without significant efforts to educate employees about alcohol and drug abuse were less likely to succeed. Thus, the company initiated a series of educational programs or seminars, using video presentations and lectures and including discussions by substance abuse experts and recovering abusers.

The general policy Champion implemented is quite brief: "Substance abuse can create safety and health hazards, cause unacceptable job performance and behavior, and adversely affect employees. Substance abuse-related problems may be cause for disciplinary action up to and including discharge." Implementation procedures are then given for common scenarios, such as how to remove an impaired employee from a Champion worksite.

After the extensive planning and education effort, Champion implemented its policy with widespread support among management and workers. To date, there has been no litigation resulting from the policy, and managers believe that the widespread support can be directly attributed to the intensity of the educational programs conducted before its initiation.

Example 2. Supervisor Training

After an employee was found dead on the job of a drug overdose at Capital Cities/ABC, management and labor at this large media company worked together to develop a comprehensive workplace alcohol and drug abuse program. The program now includes a written policy, an EAP, extensive employee education activities, and a supervisor training program.

The company president and chairman of the board began this program with top management commitment, which was communicated to all workers, and the program was funded sufficiently to make it companywide and comprehensive. A directive empowered employees throughout the company to participate in the program's development through an advisory committee of 16 workers representing all levels of the organization. While appropriate outside consultants and internal management action and support have been used along the way, Capital Cities/ABC vested most of the decisionmaking authority for program development in this committee. It is now a permanent body, continuing to advise the program.

One of the first phases of the program, which was implemented using the principles of incremental change outlined in this volume, was the development of a handbook for supervisors. This publication, *Substance Abuse in the Workplace: A Manager's Handbook*, became the central point for a supervisor training program that is exemplary in its degree of integration with the other alcohol- and drug-free workplace program components at Capital Cities/ABC. Two other critical dimensions of this program are that it is ongoing (the training does not end with the initial training sessions) and that it can be readily tailored to meet specific supervisor needs.

The supervisor training program includes the following components in addition to the handbook:

- Training sessions for managers and supervisors, coordinated by the advisory committee.
- A supervisor's guide delineating points to cover in discussing alcohol and drug abuse with employees following screening of a company-produced "trigger" film, *White Lady*, which is based on actual situations about alcohol and drugs in the workplace.
- A toll-free 800 telephone number that managers can call for confidential consultation regarding an employee whose work performance is impaired by possible alcohol or drug abuse, thus continuing the training process on a supervisor-initiated basis.
- On-site management consultation, provided by the same organization that staffs the 800 number, and a hotline for employees desiring service through the company EAP, further continuing the customized training feature of the program.
- On-demand supervisory training about personnel, legal, and medical aspects of the program—a continuing, customized training feature that respects different supervisor capacities as well as the variety of situations that may arise in a large corporation over time.

The handbook provides the philosophical grounding for the entire supervisor training program. It discusses the legal and ethical roles of a manager concerning worker abuse of alcohol and drugs, emphasizing the importance of rehabilitation while maintaining discipline, safety, and productivity. The handbook outlines the services available to workers and managers through the company program. It also describes how managers might handle either

voluntary or involuntary confrontation and provides an explanation of various illicit drugs and their effects.

Since documentation is very important in any disciplinary action that may need to be taken as a result of a substance abuse problem, the handbook also encourages managers to track performance problems with great detail. A tracking sheet for employee performance problems is included as an appendix to the handbook.

Following the incremental change approach, some components of the Capital Cities/ABC program were deliberately not introduced until others were operating well. For instance, the company and its advisory committee decided to delay implementation of a preemployment drug testing program for 2 years, including a year of investigating and planning what kind of testing program should be implemented.

Example 3. Employee Education

Commonwealth Edison is a large utility company that has developed a comprehensive employee education program. The program is designed to support and supplement other components of the company's overall alcohol- and drug-free workplace program, which includes a major EAP effort and outreach to employees' family members.

Independent of the workplace program, Commonwealth Edison publishes a regular newsletter, *Edison Health Quarterly*, which addresses worker and family health issues. The first step in the employee education program was to develop a special issue of this publication, entitled "Towards a Drug-Free Work Environment." It was sent to all employees, accompanied by the vice president's "Dear Employee" letter on the newsletter cover. It explained that the special issue was designed to help workers "understand the problem of drug abuse and to enable [them] to fight back."

This special issue covered a number of other components of the Commonwealth Edison alcohol- and drug-free workplace program and also described available community resources. Topics covered include

- a description of how the company's EAP works
- a discussion of how workers and family members can best understand the medications prescribed to them by their physicians
- a discussion of how to recognize signs of possible alcohol or drug abuse among children
- a discussion of characteristics of adult children of alcoholics
- a listing of local support groups and national hotlines for those with substance abuse problems
- a special column on the growing number of women with alcohol or drug problems
- a crossword puzzle to test the reader's knowledge about alcohol and drug abuse
- a return card to obtain more written information about substance abuse from the EAP

Besides supplying additional information from Commonwealth Edison's resources to those who sent in the return card, the company also provides each employee with a booklet, *Your Guide to Drug and Alcohol Awareness*. The booklet contains the company substance abuse policy, a description of its EAP, a list of references, and chapters on the nature of

alcohol and drugs and how they are misused. It also contains information on the effects of various illicit drugs, treatment, and prevention.

Example 4. Employee Assistance Program

Established in 1984, the Entertainment Industry Referral and Assistance Center (EIRAC) is a consortium model EAP that serves more than 250,000 Hollywood film and television workers. This umbrella EAP is funded by a number of large entertainment organizations. EIRAC provides assessment, referral, and crisis intervention services for any individual employed in the Hollywood film and television industry, as well as for their families. In addition to arrangements with key Hollywood motion picture and television companies, the center has contracts with union organizations such as the Motion Picture and Television Fund and the Directors Guild of America to provide contractually mandated services for some of the many unionized Hollywood workers. It also offers management and supervisory education at the worksite.

This umbrella EAP was founded in response to the growing perceptions of a substance abuse crisis in the entertainment industry in the early 1980's, following the deaths of actor John Belushi and several other celebrities and widespread reports of alcohol and drug abuse on the sets and on locations of film and television productions. Congressional hearings were even held on the problems of substance abuse in the entertainment industry and on the depiction of such abuse in entertainment media, with both industry leaders and celebrities testifying.

EIRAC has a 24-hour hotline that handles calls for assistance or information about the program. The center's offices are located within easy commuting distance of most of the entertainment companies it serves.

EIRAC is designed to supplement, not replace, the numerous EAPs already operating in many of the major film studios and the three television networks. For companies with existing EAPs, the center provides a means for keeping current and for communicating with other programs and professionals working within the industry. Workers and their family members who might hesitate to make their first program contact within the company that employs them can instead use EIRAC's confidential service. For the many companies that do not have EAPs, EIRAC serves as the primary resource for dealing with alcohol and drug abuse problems, as well as personal problems among employees. While the larger employers in the entertainment industry have significant financial resources, the vast majority of employers served by EIRAC are small companies and unions that have very limited resources.

EIRAC's history provides a good example of incremental change. Incremental change was needed both to overcome resistance to EAPs in the entertainment industry and to work successfully with the limited program resources in its early years. Developments have dramatically changed the center's options for service to the entertainment industry.

The EIRAC program was the result of a carefully orchestrated, volunteer-coordinated organizational change program over a 2-year period. This incremental change intervention included the following features:

- Creation of a volunteer task force, consisting of human resources executives from the major motion picture studios and television networks, labor union representatives, and several key figures in Hollywood who had already been involved in alcohol and

drug abuse programming. This broadly representative group lent both influence and credibility to the effort to create an alcohol and drug abuse program that would serve the entire industry. The task force also included a pro bono consultant—a health professional experienced in service program development who had also worked as a consultant and educator in the entertainment industry for many years.

- The presence of an outside "angel" organization—the Scott Newman Foundation (founded by Paul Newman and Joanne Woodward following the drug-related death of their son)—which provided initial coordination of the effort and modest financial support.
- Development of a carefully articulated needs assessment and resource evaluation, including an informal, but thorough, study of industry needs, the responses to substance abuse that had already occurred, the challenges to be faced (negative attitudes, the need for financial support, etc.), and how best to overcome them.
- Staging of an organizing conference, at which industry leaders discussed the need for an industrywide alcohol and drug abuse program (citing such factors as the geographic concentration of the industry, the tremendous casual labor force moving from one employer to another, and the intense seasonal variations in employment).
- Development of a written strategic plan for the center's creation in late 1984, which directed that EIRAC would initially be a small program, offering a limited range of high-quality services that could grow as the organization's experience and financial base expanded.

EIRAC's operations have been directed by a strong board comprising persons with leadership roles in both management and labor. A professional advisory board chaired by the outside consultant also helps to guide the program. From its inception, EIRAC has been at the forefront of alcohol and drug abuse education and intervention activity in the industry it serves. It has also taken a leadership position on the acquired immunodeficiency syndrome (AIDS) health crisis, helping to shape an industrywide task force on AIDS, which since has become a formal program of the center.

From its beginnings, the center has operated under two key assumptions about alcohol and drug abuse and the entertainment industry. First, problems of substance abuse in the entertainment industry are shaped by a number of conditions peculiar to the profession, including its high public visibility and high-stress working conditions. An EAP's services and the treatment program it accesses must be cognizant of these special circumstances. Second, there is a substantial casual labor force in the industry—people move from one workplace to another on an irregular but frequent basis—making it difficult for in-house programs to be fully effective. As an umbrella program, EIRAC is able to counteract this phenomenon to some extent and to provide some services for companies too small to have an EAP.

EIRAC staff recognize other complications of being an abuser of alcohol or drugs in the entertainment industry: the tolerance of and even support for abuse that exists in some quarters; the enormous pressures (including the boredom that may tempt a highly paid person who doesn't work for several months at a time to turn to alcohol or drugs); and the likelihood of recidivism if the person returns to the work environment that contributed to abuse in the first place. In selecting treatment and rehabilitation programs, the staff is aware that people in the entertainment industry view themselves as a special breed; recognition of the psychological reality of this self-identity on the part of treatment professionals increases the

likelihood that treatment will work. Self-help groups like Alcoholics Anonymous and Cocaine Anonymous have chapters that specialize in assisting those employed in the entertainment industry. Some of these groups hold meetings right on the film studio lots.

Example 5. Drug Testing

Tyson Foods developed a comprehensive alcohol- and drug-free workplace policy that included drug testing. The program includes testing supervisory and management personnel, testing employees who receive a compensable injury requiring outside medical treatment, just-cause testing (e.g., involving a worksite accident), preemployment screening, and testing vehicle drivers.

The senior managers of the company were concerned that employees might react negatively to this new policy and even resist its implementation, particularly because the drug testing provisions are rigorous. In order to ease employees' fears and promote greater acceptance of the new policy, Tyson Foods engaged in a number of developmental and educational activities.

The company had already established a system of peer groups—essentially quality circles in which employees who work together discuss work issues with the aim of improving product quality. Tyson Foods decided to use these peer groups as a channel for communication and dialogue about drug testing and other aspects of its alcohol- and drug-free workplace policy.

Tyson Foods conducted a series of luncheons for the peer group leaders at which the goals, objectives, and components of the policy and its resulting programs were described in detail. Peer leaders were also given materials they could use in describing the Tyson Foods policy to their peer group members. After this peer group discussion, the company conducted a series of employee roundtables at which any employee could raise questions or concerns about the policy with senior management personnel.

The company discovered, somewhat to its surprise, that not only did this three-part communications strategy result in better acceptance of the workplace policy and its drug testing component, but many workers expressed gratitude that management was forcefully addressing the problem. Tyson Foods also discovered that the local media picked up on their planned policy. The publicity generated considerable goodwill and community support for the company. To date, no policy-related litigation has been initiated, and the policy has been written into three union contracts. Tyson Foods also continues to train its employees on topics about alcohol and drug abuse in the workplace.

6. Special Issues

Workplace alcohol and drug abuse programs are developed and operated in the context of many complicated, often conflicting, issues. These include the characteristics of addiction and its consequences, aspects of the workplace with respect to its human resources, and the nature of substance abuse treatment, especially with regard to certain groups of workers. In this chapter, a number of these special issues are briefly discussed, including the characteristics of drugs and addiction, human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS), health insurance, managed health care and cost containment, quality of treatment, relapse, and special services.

Some of these topics are still on the cutting edge of our knowledge base and urgently need further exploration (e.g., how to provide culturally sensitive alcohol and drug abuse programs for ethnic/racial populations, and how to provide adequate health benefits coverage and worksite accommodations for workers with AIDS). Other subjects represent familiar ground that needs revisiting, such as how to handle self-medication for stress. Still other issues are discussed because they are important for the future vitality of workplace substance abuse programs—in particular, health care cost containment, which most observers predict will enormously influence the attitudes of employers toward programs for alcohol and drug abuse (i.e., if prevention and treatment can be shown to effectively contain costs of employee health benefits, employers will support them).

The following special issues are presented with the suggestion that the strategic planning process advocated in this volume answer the following two questions: (1) Is the issue relevant to a given workplace and its work force? (2) If it is relevant, how might it best be addressed? Sometimes, an employer might decide not to address a particular issue even if it does seem likely to occur (e.g., because of cost considerations), but the overall strategic plan will be stronger if that decision is made deliberately. Experts on strategic planning agree that conceptual foresight is an essential part of the planning process. That is, those developing a workplace substance abuse program need to identify the likely sources of challenge and uncertainty, so that strategies for dealing with these potential problems can be laid out in advance as part of the overall strategic plan.

The special issues that follow are discussed only briefly because of space limitations; interested readers are encouraged to consult Workplace Resources and the Bibliography for more information. Many of these issues are addressed in chapter 4 as part of program implementation, and other suggestions for employers can be found in chapter 5, in which model program components are presented. A few questions for employers' consideration in program design follow each special issue. These are intended only as starting points for considering how an individual program might best be designed.

Characteristics of Alcohol and Drugs and Addiction

Cocaine

According to the Substance Abuse and Mental Health Services Administration's (SAMHSA) 1993 National Household Survey on Drug Abuse, 3 million people had used cocaine in the past year, of whom 1.3 million had used cocaine in the past month. Cocaine has received the greatest amount of attention in the recent furor over alcohol and drug abuse, and for good reason. It is now one of the most popular illicit drugs in use and, especially in the form of crack cocaine, it is extremely addictive—possibly the most addictive illicit substance that is widely used. Cocaine can be a popular drug to use at work, partly because it is easy to conceal, partly because it is still considered glamorous by some despite changing attitudes toward alcohol and drugs, and partly because the intense response it generates can give users the false feeling that they can do their jobs better and more quickly.

Indeed, the physiological effects of cocaine initially accelerate concentration and intensify feelings of well-being. However, users rapidly develop tolerance, and significant potential for physical damage develops as dosage increases when users strive to recapture that initial high. Occasional use can cause a stuffy or runny nose, while chronic snorting can ulcerate the mucous membrane of the nose. Injecting cocaine with unsterile equipment can cause hepatitis or other infections; shared needles can transmit HIV, which causes AIDS. Furthermore, because preparing "freebase" cocaine involves using volatile solvents, deaths and serious injuries from fire or explosion can occur. Though few people realize it, overdose deaths can occur whether the drug is injected, smoked, or snorted (especially if cocaine is taken in combination with other drugs or alcohol). Death results from multiple seizures followed by respiratory and cardiac arrest.

Employer Questions. Is there reason to believe your workplace includes a significant number of cocaine users? How will your program tailor services to meet the needs of this special population? Do your program personnel have an adequate understanding of the nature of cocaine addiction and how to deal with it?

Marijuana

Marijuana remains the most commonly used illicit drug in the United States, despite some decline in use over recent years. The health consequences and performance impairment effects of marijuana have been debated widely in the scientific and medical community for many years. What cannot be debated is that many Americans have tried marijuana at least once, and an estimated 9 million people have used the drug in the past year, according to the 1993 SAMHSA National Household Survey on Drug Abuse. Evidence is accumulating from laboratory studies and investigations of industrial accidents that marijuana does impair certain kinds of work performance. Its effects on heavy users last a considerable time after ingestion.

Employer Questions. What is the attitude of your work force toward marijuana? What special education efforts might be developed to convince workers that marijuana use is a significant problem, including a possible threat to their safety?

Alcohol

Many workplace programs began with services for persons with alcohol problems. In some cases, the orientation of services may still be driven by this history, with insufficient attention given to the special nature and problems of other drugs of abuse. However, substance abuse experts today agree that alcohol abuse still is by far the most pervasive addiction-related problem in American society. The SAMHSA 1993 National Household Survey estimated that 11 million Americans were heavy drinkers (5 or more drinks per occasion 5 or more times within the past 30 days). No workplace substance abuse program is complete without serious policy and program attention to workers who abuse alcohol, often in combination with drugs.

Employer Questions. In an evolving program, has the pendulum perhaps swung too far, so that alcohol abuse among the work force is not receiving adequate attention? Are there any "hidden messages" in workplace policy about the acceptability of alcohol abuse (e.g., serving alcohol at workplace functions without a clear statement about appropriate drinking behavior)? (See below for a further discussion of multiple addiction.)

Methamphetamine and "Ice"

"Ice" is a smokable form of methamphetamine, a stimulant also known as "speed" or "crystal meth." Marijuana and alcohol are often used to "come down" from a methamphetamine high. The incidence of methamphetamine use is higher among blue collar workers, although "ice" is used by a wide range of people, particularly those in their late teens to early 30's. The drug is highly addictive and can produce impaired judgment, impulsiveness, chronic insomnia, and severe psychiatric symptoms, such as hallucinations and paranoia. Although the subject of some recent media attention, "ice" is still not as widely known to the general public as other drugs. Like other stimulants, it may be used in the workplace in an effort to increase productivity or alertness, especially among employees who have long or unusual work hours. According to the 1993 SAMHSA National Household Survey, 853,000 Americans have used a stimulant within the past year.

Employer Questions. Do your EAP personnel and others responding to alcohol and drug abuse issues have training about methamphetamine, "ice," and other such stimulants and how to deal with these illicit drugs? Has there been a systematic survey of working conditions in your organization to determine what locations, programs, or specific workers might be particularly susceptible to this drug?

Heroin

In the minds of many middle-class people, heroin is used only by inner-city hardcore illicit drug users. They would be surprised to learn how many professionals, executives, and blue collar workers—who certainly do not think of themselves as typical "junkies"—regularly use this drug. In fact, according to the SAMHSA 1993 National Household Survey, 2.29 million Americans have used heroin, 245,000 of them within the past year. Heroin use is frequently found in conjunction with cocaine use, often as self-medication for some of the consequences of frequent cocaine use. Heroin users tend to be older than other drug users—half of them are over the age of 35.

The physical dangers of heroin use depend on the specific opiate used, its source, the dose, and the way it is used. Most of the dangers are caused by using too much, using unsterile needles, contamination, or combining the drug with other substances. Over time, opiate users may develop infections of the heart lining and valves, skin abscesses, and congested lungs. Infections from unsterile solutions, syringes, and needles can cause illnesses such as liver disease, tetanus, serum hepatitis, and AIDS.

Employer Questions. Are your supervisors and your substance abuse program personnel aware of the potential for heroin use among your work force? Do your program personnel have a good understanding of locally available programs for treating heroin dependency?

Designer Drugs

These are versions of controlled drugs that are created in underground labs by chemists. Because their chemical structure is slightly different from the illicit drugs they mimic, at first these synthetic drugs were considered licit. There are now laws that make it easier to regulate them. Often they are 50 to 100 times more powerful than their counterpart drugs, making them intensely addictive and extremely dangerous in terms of the potential for an overdose.

Employer Questions. Are your program staff adequately knowledgeable about designer drugs? Are there any conditions in your workplace (e.g., access to appropriate chemical equipment for manufacture) that increase the likelihood of such drugs appearing there?

Self-Medication for Stress

Most recent media attention to alcohol and drug abuse has emphasized psychoactive substances used "recreationally," for the pleasurable feelings these substances release. Users claim they feel more creative, witty, charming, and in control—especially when the drug is cocaine. Much less attention has been given to another major reason people abuse alcohol and drugs: their work lives, and perhaps their personal lives as well, are extremely stressful, and significant alcohol and drug abuse is an effort to self-medicate for stress. Often their physicians are in complicity in this process, prescribing tranquilizers and other drugs for stress without exploring alternatives.

Employers who place high expectations on their employees, but give them little support, are likely to raise stress levels in workers both on and off the job. Employees who become dependent on medications prescribed to help them through especially stressful periods are likely to continue taking the drugs even when the stressing conditions are ameliorated or ended. At that point, drug dependency becomes addiction unless there is some kind of intervention.

In order to deal with substance abuse resulting, at least in part, from self-medication for stress, employers need to look broadly at the quality of life in the workplace and its impact on abuse of alcohol and drugs. In seminars and conferences on the subject, employer representatives have started to report how work load, ineffective supervision, and rapid technological change may contribute to stress, leading to increased alcohol and drug abuse. Many workplaces are beginning to look at stress management training and organizational

interventions to reduce sources of stress in the workplace as a direct part of an effective workplace substance abuse program. For instance, many EAPs offer stress management seminars as part of their service package.

Employer Questions. What evidence do you have of overall stress levels among workers? Does the organization have a stress management program? How might this program connect with the substance abuse program? What changes in the work environment might ameliorate stress and thus reduce temptation to abuse alcohol and drugs?

Multiple Addiction

In many alcohol and drug treatment programs today, the person addicted to only one substance is rare. Abuse of combinations of two, three, and even four different substances is becoming more and more common. Multiple addictions are hard to treat, the prospects for overdose or severe physical side effects are great, and recidivism rates are high. Alcohol and cocaine, and alcohol combined with tranquilizers, are the most common combinations. Users of cocaine and "ice" may be particularly likely to use other drugs to "come down" from these drugs. Multiple addiction often begins when tranquilizers and sleeping pills are used as an alternative to heavy drinking or to ameliorate the effects of alcohol or drug abuse.

Employer Questions. What evidence exists about multiple addiction in your work force? Are your program staff adequately knowledgeable about how to assess and deal with this population? Does your supervisory or worker education program include information about the dangers of mixing drugs?

Alcohol and Drug Post-Use Syndrome

As the number of high-dosage substance abusers increases, medical researchers are becoming concerned about the increasing incidence and effects of alcohol and drug post-use syndrome, a set of signs and symptoms that includes disruptions of brain function and effects on the body's immune system long after the drugs have been administered. Physical illness, brain damage, and impaired judgment and physical performance can appear days, weeks, or months after cessation of heavy alcohol or drug use. This situation raises questions about whether employers may indeed have a right to know about past substance abuse among prospective employees. Employers must also understand long-term rehabilitation issues for former alcohol and drug abusers currently in their work force. Medical science is only starting to understand the long-term effects of chronic abuse of alcohol and drugs; clearly, the body takes a long time to return to normal, if it ever does, after the significant impact of heavy substance abuse.

Employer Questions. Does your workplace include jobs that would be significantly impacted by alcohol and drug post-use syndrome (e.g., those involving safety issues or requiring precise intellectual and physical control)? Does it have an on-site self-help group to support employees who have undergone treatment for heavy abuse of alcohol or drugs?

HIV/AIDS and Injected-Drug Use

It is estimated that more than half a million Americans have contracted AIDS and 311,000 have died from the disease. Injected-drug use is a transmission vehicle for HIV infection, both directly—through sharing infected needles or "works"—and indirectly, through the lowered impulse control that results from being high on alcohol or drugs.

According to statistics from the Centers for Disease Control and Prevention (CDC), U.S. Public Health Service, more than 25 percent of current AIDS patients in the United States are injected-drug users. This percentage will inevitably increase, since needle sharing is the prime mechanism for transmitting HIV. Public health officials and epidemiologists are projecting a sharp increase in AIDS cases, and a disproportionate number of cases will result from the behaviors of injected-drug users. Many environmental and cultural factors make it particularly difficult to effect behavioral changes in injected-drug users. Unless the behavior of injected-drug users changes radically, epidemiologists predict that not only will the lives of addicts who share needles be in jeopardy, but the lives of their sex partners as well.

Because of the ways in which HIV infection is transmitted, AIDS strikes a disproportionate number of working-age people. According to a recent study conducted by the research and consulting firm Foster Higgins, more than 75 percent of large employers in the United States (with work forces over 5,000 employees) have recorded cases of AIDS among employees or dependents covered under their health care plans, with an average of six cases reported per employer.

The total medical care cost for treating a person with AIDS had leveled off at about $75,000 in 1988 dollars, according to the National Center for Health Services Research and Health Care Technology. AIDS patients incurred $3.3 billion in direct medical expenses in 1989, 40 percent of which was paid for by businesses and private insurers. These medical expenses were expected to total $7.8 billion by 1993.

As new treatments such as drug therapies enable people with AIDS to live longer, they will remain on the job longer, but their incidence of disability will increase. This situation will increase health insurance costs, job accommodation costs, and costs from persons utilizing long-term disability insurance provisions. Thus, AIDS is a significant health benefits cost factor for employers, along with heart disease, cancer, and other medical conditions.

Beginning in 1983, a group of large corporations in San Francisco pioneered the development of policies and programs for dealing with AIDS in the workplace. Wells Fargo Bank, Syntex Corporation, Pacific Telesis, Bank of America, Levi Strauss, and others took a leadership position when the rest of America still knew little about this disease. Much progress has since been made by public and private sector employers, labor organizations, government health agencies, researchers, and management experts. As a result, there are now a number of resources for employers and labor organizations to draw upon.

Employer attitudes toward HIV and AIDS issues are improving, and more employers in both the public and private sectors are willing to take action. However, many companies already regard AIDS as an outdated issue, and ignore or deny the warning signs that it is a problem in their own environment—or will be in the near future. Backer (1993) reached this conclusion from reviewing a number of recent magazine and public interest group surveys. For instance, a recent *Forbes* magazine survey found that fewer than 25 percent of American workplaces have a defined policy that deals with AIDS. *Crain's New York Business* reported

a 1989 subscriber survey showing that 92 percent of respondents had no AIDS policy and that 82 percent had no plan to create one in the near future. Similar findings emerged from surveys conducted by Crain publications in Chicago, Detroit, and Cleveland. A Philadelphia Commission on AIDS study in 1988 found that 68 percent of responding businesses had no AIDS policy.

One of the most common levers for change in the employer community's attitude about any human resources issue is the threat of legal action. The number of lawsuits concerning discrimination or harassment related to AIDS in the workplace is on the rise, and some local and State ordinances have been passed to provide a legal framework for enforcement. One of the most powerful forces on the workplace scene for the rest of the 1990's is likely to be the Americans with Disabilities Act, which became law on July 26, 1990. This Act forbids discrimination in employment and housing for HIV-infected persons.

Worker attitudes and knowledgeability about AIDS were surveyed by Judith Barr and Leon Warshaw for the New York Business Group on Health and the Gay Men's Health Crisis Center. There were responses from 3,460 employees in 12 worksites that had implemented an AIDS education program. Workers responding had fairly accurate knowledge about how AIDS is and is not transmitted, and had generally favorable attitudes toward other employees with AIDS. About 79 percent of the respondents had participated in at least one of their workplace's scheduled educational activities. Educational programs that had the most impact were fairly extensive—they typically included a videotape, discussion session, and print materials. One-on-one counseling was available, and all workers were encouraged to attend the program.

Despite a high level of knowledge, some employees had misconceptions about the transmission of HIV infection through casual contact, and some were skeptical about information being disseminated through the mass media and by scientific experts. Some workers with a good understanding of the facts about AIDS transmission still expressed negative attitudes. A sizable minority of the total respondents also held negative views—for example, over 30 percent thought employers should screen new employees for AIDS and almost 10 percent thought that employers should be able to terminate current employees simply because they have AIDS.

Employers and labor unions throughout the United States are creating policies, worksite education and prevention programs, and services for workers who are HIV positive or have symptoms of AIDS, as well as needed services for coworkers. Publications, technical assistance (some of it free), and consulting services are available for those wishing to develop policies and programs. There is a national newsletter and a computer bulletin board devoted exclusively to the subject of AIDS in the workplace.

AIDS education programs are becoming more and more common in workplaces of all types. In many cases, employers have designated an organizational unit (such as a human resources department or EAP) to have ongoing responsibility for educational activities. Programs are now moving beyond basic educational activities to more complex issues, such as supervising persons with HIV infection and dealing with cultural diversity issues. Crisis management techniques are often used very effectively when the first worker with AIDS becomes known to the work force. Service programs for HIV-infected workers may include special counseling, job accommodations (work at home, job sharing), and benefits coordination. Many employers periodically reexamine their policies to see if they are in line with current knowledge about treatment resources, legal issues, etc.

The Federal Government has released guidelines for how its workers with AIDS will be treated. A set of 10 principles for the workplace, developed by the Citizens Commission on AIDS of New York City and Northern New Jersey, has been adopted by corporations all over the country. The past few years have seen encouraging developments regarding the response of employers and labor unions to the challenges of HIV/AIDS infection, some leadership by the Federal Government and other public agencies, and increasing awareness and attitude change by the public. However, the following important issues remain, many of which are relevant to workplace alcohol and drug abuse activities:

- Helping smaller employers develop AIDS policies and programs. As is the case with substance abuse programming, worksites with 100 to 500 employees, or even fewer, often do not have the financial or personnel resources for this purpose; in cities with a high incidence of HIV like Los Angeles and New York, many small employers already need such programming.
- Maintaining interest and commitment to worksite AIDS activities, which many employers see as "last year's issue." (Again, there is similarity to the workplace substance abuse crisis of 1986–87.)
- Developing industrywide responses, particularly for industries concentrated in a geographical area, which bring together labor and management for long-term coordinated programming.
- Addressing increasingly complicated benefits issues—rising insurance costs, availability of insurance, coverage for home health care and experimental treatments, etc.
- Addressing equally complicated legal issues—maintaining confidentiality, employer responsibility for worker harassment, discrimination in hiring, etc.
- Developing various types of worksite accommodations, as AIDS moves from acute to chronic disease status, and more and more persons with AIDS continue to work.
- Moving beyond basic education to address issues such as the need to maintain safer sex behavior over time or concerns about the neuropsychological complications of AIDS and implications for supervisors.
- Providing culturally sensitive AIDS education and prevention activities for members of various ethnic/racial populations at the worksite.
- Providing AIDS education and prevention activities for women at the worksite, particularly concentrating on women who are sexual partners of injected-drug users.
- Addressing attitude change among decisionmakers, managers, and workers regarding homophobia and alcohol and drug abuse.
- Addressing attitudes toward death and dying—often unrelated to any self-perceived risk of HIV infection—that may engender resistance among top management in workplaces.
- Addressing the resistance among many employers to the idea that their work force may include injected-drug users.
- Educating workers and employers about the risk of AIDS associated with lowered impulse control resulting from alcohol or drug use.

- Providing linkages between employers and substance abuse treatment facilities, prevention organizations, and rehabilitation organizations, among others, in regard to AIDS prevention and service—community-wide response systems are needed, and few are in place.
- Exploring the possible role of worksites in encouraging volunteer services for persons with AIDS as the epidemic expands within the community of injected-drug users, which does not have an internal support system such as that in the community of gay men.

Employer Questions. How might your policy on AIDS in the workplace be integrated with a policy on alcohol and drug abuse and other health problems? Are your program staff adequately knowledgeable about AIDS and drug use, including risk factors from injected-drug use and those stemming from lowered impulse control as a result of any type of substance abuse?

Health Insurance, Managed Health Care, and Cost Containment

Health Insurance

Adequate health insurance benefits for covering inpatient and outpatient alcohol and drug abuse services are an important component of any workplace program. EAP and employee benefits personnel need to work with top management to review insurance coverage. Such a review can result in a decision to add coverage for workers (assuming that the increased costs will be offset by increased productivity and reduced costs for other health care). In some cases, the employer can advocate with the insurance company or its case management consultant for coverage of longer term (but lower cost) outpatient services, which may be critical to reducing the problems of employee relapse.

Employer Questions. What is the quality of communication between employees and health benefits personnel? What provisions exist in the current insurance portfolio for outpatient and inpatient services, counseling for family members of an alcohol- or drug-abusing person, and other nontraditional coverage? Is the current insurance package adequately meeting the treatment needs of workers with alcohol or drug abuse problems?

Managed Health Care and Cost Containment

Since the 1950's, it has become increasingly common, almost universal, for employers to pay many of the health care costs for workers and their families. Employers have to be concerned about more than the adequacy of health benefits for workers abusing alcohol or drugs—they must also consider the cost of these benefits. The rising cost of health benefits for workers has become a matter of central economic concern for employers in the 1990's, with double-digit annual increases becoming common.

Some corporations now report they spend more money each year on health benefits than on the raw materials they use to make their products. Thus, health care cost containment is a major concern for all employers, and this affects alcohol and drug abuse treatment in two ways. First, employers are wary of long-term, expensive substance abuse treatment pro-

grams, and health insurance coverage for alcohol and drug abuse is often limited. On the other hand, effective treatment of alcohol and drug abuse can often reduce workers' utilization of other health care benefits (as well as increase worker productivity), effecting an overall cost savings to the employer.

To hold down costs but still offer good health benefits for workers and their families, many employers are turning to managed health care in its various forms. Most such programs involve a third party, often an outside company or consultant, who may have many roles:

- to design and review benefit plans.
- to oversee how workers utilize health benefits (to prevent inappropriate or excessive use).
- to contract with health care providers at favorable rates.
- to review the quality of health services provided.
- to provide a central point of entry to the employer's health benefits system, preventing waste and duplication.

In short, managed care reduces costs and maintains quality by monitoring and controlling how employers administer and workers use various health benefits programs.

Each of these managed health care functions has important implications for alcohol and drug abuse treatment provided through employer-paid benefits. For instance, managed care activities may limit the substance-abusing worker's access to treatment programs, or may encourage outpatient rather than inpatient care.

Employer Questions. What cost-containment measures are you currently taking that could be integrated with your program for alcohol and drug abuse? How does your EAP or other workplace substance abuse programming interface with any managed health care activities of your organization?

Quality of Treatment and Relapse

Quality of Treatment

The quality of local treatment programs should be assessed periodically to determine how well they provide detoxification, counseling, and rehabilitation services for workers with alcohol or drug abuse problems. Careful attention should be paid to how a treatment program addresses recidivism, discussed in the next section. For instance, some treatment programs have special features that are designed to reduce or prevent relapse, and others offer additional treatment free of charge within a certain time frame if the individual relapses. Some guidelines for determining the quality of treatment facilities are given in chapter 4.

Employer Questions. What experiences have other local employers had with specific treatment programs? What resources (e.g., State agency, city or county substance abuse agencies, and local chapters of self-help groups) are available to help assess the quality of treatment programs?

Relapse

People who have completed an alcohol or drug abuse treatment program have a high rate of relapse, estimated to be 60 percent or more in some instances, especially in the case of illicit drugs such as cocaine or heroin. The nature of alcohol and drug abuse is such that most abusers need more than one treatment. The road to long-term recovery should include both treatment to establish and promote continued abstinence, and followup treatment (often called aftercare) to prevent or minimize relapses. Effective programs will provide both types of treatment. Even a good inpatient or outpatient treatment program may be ineffective unless there is provision for long-term aftercare (e.g., regular outpatient counseling sessions with a professional, participation in self-help groups such as Narcotics Anonymous and Alcoholics Anonymous, followup drug testing, and related approaches). The nature of recovery for many alcohol or drug abusers will include brief periods of relapse, followed by ever-increasing periods of abstinence. Treatment aftercare is essential to promote long-term recovery.

There are other issues for employers to consider. For instance, if the work environment is highly stressful or conducive to alcohol use, a return to that environment may in itself contribute to the relapse. Employers may need to consider modifying the work assignment for the recovering abuser of alcohol or drugs, while maintaining appropriate expectations for productivity. EAPs often can provide certain types of support in the workplace for workers who have been through treatment, thus preventing relapse. Some workplaces also have peer support groups, often organized using the Alcoholics Anonymous model, that provide help for workers who are coping with the difficulties of remaining free of alcohol and drugs.

Employer Questions. How can workplace characteristics or the nature of individual jobs be modified to help the recovering substance abuser stay clean and sober? How do treatment facilities in your geographic area attempt to prevent and minimize the problems of relapse? What role does the EAP have in helping to support your employee's recovery?

Special Services and Union Cooperation

Services for Executives

Use of cocaine and other illicit drugs occurs among executives. The methods of identifying such executives and referring them to treatment will differ from methods used with workers in lower level jobs. For instance, it is often easier for an executive to conceal patterns of abuse behind closed doors (often with the unwitting complicity of secretaries and assistants). Also, executives are more likely to have the disposable income needed for heavy alcohol and drug use habits. Executives may require specialized treatment programs that provide both a setting commensurate with their lifestyle and attitudes and, in some cases, the possibility of continued work, because their talents and skills may be difficult to replace.

Employer Questions. What informal evidence exists about alcohol and drug abuse in the executive ranks of your workplace? What steps need to be taken to avoid damage to the substance abuse program by high-level resistance? How can executive job roles be modified to reduce risk of alcohol and drug abuse or to make recovery more effective for those who

are already addicts? Are policies equally enforced for executives and other levels of workers in the organization?

Services for Women

Patterns of alcohol and drug abuse in women differ significantly from those in men. According to recent estimates, women use 80 percent of all amphetamines consumed in the United States and 72 percent of all tranquilizers. In short, with all other factors held constant, women may be more likely than men to abuse licit drugs. As women move up the corporate ladder, they are also more likely to become alcohol and drug abusers through self-medication for stress, just as their incidence of heart attacks, ulcers, and other stress-related disorders rises with workplace participation. These and other special circumstances require treatment programs that are sensitive to the unique needs of women and their families.

Employer Questions. How can women, including women executives, in the organization be included in planning a workplace substance abuse program? What anecdotal evidence exists about alcohol- and drug-related problems among women workers in your organization? What special needs for family support must be met while women who are heads of households are in treatment?

Services for Minorities

African Americans, Hispanics, Native Americans, Asian Americans, and other ethnic/racial populations may have quite different cultural values and behaviors about alcohol and drug abuse. Both prevention and treatment programs may need to be modified—in content and language—to fit these cultural values. Workplaces with large minority populations may need a tailored in-house program for employee education, supervisor training, outreach, referral, and other steps. Such a program might be created and provided by persons who come from the appropriate minority group, possibly including worksite support groups, referral to specialized community facilities, and culturally sensitive and language-specific materials.

Employer Questions. What is the ethnic/racial composition of your work force? How does it relate to your alcohol and drug abuse program? Who in the organization and in the local community might offer useful consultation about designing a program to meet the special needs of a given ethnic/racial population?

Specific Industry Conditions

Earlier in this publication, findings from SAMHSA's 1991–1993 National Household Surveys on Drug Abuse showed that different occupations have different rates of alcohol and drug abuse among 18- to 49-year-old full-time workers. Other studies also have shown high rates of alcohol and drug abuse in more specific occupational areas—for instance, the entertainment industry, construction trades, the hotel and restaurant industry, and arts and entertainment. The reason for these findings may be a set of special conditions that these industries happen to share—high income, high stress levels, high degree of uncertainty about work success or failure, rapidly changing work conditions, and tolerance for substance abuse, especially in the upper echelons. These conditions appear to contribute to unusually intense involvement with alcohol and drugs, rather than anything inherent in the work or the industry

per se. To the extent that such conditions influence alcohol and drug abuse patterns, it is important for program designers to be aware of these influences and to create programs that take those specific industry conditions into account.

Programs for employees with sensitive jobs within various regulated industries—such as transportation, defense, and nuclear power—also require special consideration. For instance, many of these workers are subject to Federal drug testing requirements, and supportive programs for treatment and rehabilitation are needed to supplement the drug testing requirements.

Employer Questions. To what extent does your workplace manifest special conditions? How are the problems these conditions may produce being addressed (independent of efforts specific to alcohol and drug abuse)?

Union Cooperation

Support from labor, especially in unionized workplaces, is critical for a successful alcohol and drug abuse program. Workers must have some input in designing a program, and labor union requirements for due process and treatment of impaired workers have to be addressed. Early involvement of union leadership in designing a workplace alcohol and drug abuse program is especially critical in order for labor to support it later on. In particular, issues such as involuntary referral to a program, confidentiality, and adequacy of health care coverage for workers with substance abuse problems are of great interest to unions. Collaboration between labor and management is the key to developing a mutually beneficial and effective alcohol- and drug-free workplace program.

In some industries, labor unions actually operate EAPs, which are typically referred to as Member Assistance Programs. In such instances, of course, the questions about appropriate involvement are redirected to the union—is management appropriately involved in the design, execution, and review of the program?

Employer Questions. Based on past experience, what issues are most likely to concern labor in your workplace with respect to alcohol and drug abuse? How can labor be appropriately involved in designing and executing the program? If there is no labor union, what other mechanisms for labor involvement are possible?

7. Guidelines For Small Employers

Overview

Fifty-eight percent of all Americans work for organizations with fewer than 500 employees. Many of the 40 million new jobs created in the last 10 years are in companies with fewer than 200 employees; in fact, a large number of these companies have only a handful of workers, and often some of these workers are part-time employees.

By comparison with the large corporations whose workplace alcohol and drug policies and programs have been the model for much of the discussion in this volume, small employers—public or private—believe they cannot afford a comprehensive program to prevent and address worker substance abuse. Even though Employee Assistance Programs (EAPs) exist in smaller work settings, they are less likely to be found in the smallest companies. Other components of a workplace program discussed here, such as prevention education or supervisory training, are also less likely to be present. There is also a problem among smaller employers in providing adequate health insurance coverage so that workers who need assistance can access appropriate services.

Despite these challenges, there is no question that smaller employers can benefit from the presence of workplace programs for alcohol and drug abuse. In a 10-person workplace, one worker with a significant abuse problem can be devastating to productivity and profits. Employers of all sizes are taking seriously their social responsibility to respond to worker health issues, including those related to alcohol and drug abuse.

The studies cited earlier make it clear that small employers are increasingly developing and implementing components of a workplace alcohol and drug abuse program. Some program activities may be limited in scope, and certain program components, such as drug testing, often do not have longevity.

Nonetheless, there is increasing motivation to address workplace alcohol and drug problems, even among smaller employers. Some motivation results from increased attention and expectation within the employer community, some from the demands that workers (or unions) place upon employers, and some from legislation such as the 1988 Drug-Free Workplace Act, which affects many small employers with Federal Government contracts having a value of $25,000 or more.

A policy that addresses alcohol and drugs in the workplace and a relatively simple worker education program of short duration (e.g., a lunchtime seminar) are often the initial, minimal responses made by the small employer. Sometimes these activities may simply be intended to meet the requirements of the Drug-Free Workplace Act. In some cases, small employers

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have attended a community-based workplace prevention seminar or purchased materials offered by commercial consultants that claim to allow the employer to meet the Drug-Free Workplace Act's requirements. Such activities may indeed meet the letter of the law, but they are often inadequate to deal with the challenges of alcohol and drug abuse in even a small workplace.

In fact, many small employers are beginning to engage in more comprehensive responses. For instance, most EAP experts stipulate that 200 employees is the minimum number needed to establish an in-house Employee Assistance Program. However, some smaller employers are banding together in community-based Chamber of Commerce or local business group consortia to contract with an outside EAP provider at a reasonable fee. Others create an informal program, relying on volunteer contributions from workers and community resources. There is evidence that workplace prevention activities are increasing—even in the very smallest workplaces—in areas such as establishing a workplace substance abuse policy, educating employees and supervisors, providing EAP services, and conducting drug testing.

Increasingly, small businesses are developing workplace alcohol and drug abuse programs through collaboration between top management and the work force. Senior managers, perhaps in coordination with a human resources professional (typically a personnel director), often provide the impetus behind such programs, which use a variety of community-based resources to compensate for the lack of in-house programs.

While the guidelines and methods set forth in this publication may have to be modified substantially to meet the needs of small business, the three basic commitments remain the same: top management support, resources, and strategic planning. The incremental change approach may also be of great value to the smaller employer, since the financial cost and organizational effort required for a workplace substance abuse program may prevent all needed components from being implemented simultaneously.

Basic Strategies for Small Employers

Small employers might consider the following strategies in developing and implementing a workplace substance abuse program:

- Join with other small employers in the same geographic area (or the same type of business) and develop a consortium program (see chapter 3 for a definition, the Special Resources section later in this chapter, and chapter 5—the Entertainment Industry Referral and Assistance Center—for examples of this type of program).
- Encourage a local business or industry association to provide workplace substance abuse educational seminars and to coordinate information and program development. Local Chambers of Commerce may also be likely to serve in this role (perhaps also serving as the organizing unit for a consortium).
- Subcontract for services from an existing program in a nearby large work organization.
- Join with other local employers to retain a consultant specializing in program development for a group consultation (perhaps leading to the generation of several individual company programs or a consortium).
- Contract with a health maintenance organization (HMO) or a preferred provider organization (PPO) that provides treatment services for alcohol and drug abuse.

- Contract with a local provider for Employee Assistance Program services.
- Arrange volunteer support for a program through local alcohol or drug councils, local EAP professional groups, self-help groups, or perhaps even through an employee who is recovering.
- Arrange ongoing educational seminars and awareness programs through local prevention programs and treatment providers, which may provide such services on a complimentary basis.
- Ensure employee insurance covers alcohol and drug abuse treatment. Some health and workers' compensation insurance programs offer related incentives and may provide EAP services as a part of their coverage.
- Speak with and learn from other employers who have developed effective workplace substance abuse programs to determine how such programs can be developed despite limited resources.

Special Resources

The National Federation of Independent Businesses, local Chambers of Commerce, and many other organizations may have resources available for the smaller employer. The National Leadership Coalition on AIDS has recently published guidelines for small employers, which may be useful for developing a human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) component in a workplace substance abuse program. Industry associations may also have resources available.

In some communities and industries, it may be possible for small employers to benefit from the experiences and resources of larger employers. For instance, Employee Assistance of Central Virginia (EACV) in Lynchburg, Virginia, is a nonprofit consortium EAP that provides services to approximately 20,000 employees in over 50 work organizations. This consortium started in 1977 when the community's largest employer, Babcock & Wilcox, was approached by two individuals interested in establishing an EAP consortium. The company was impressed with the marketing presentation, and, in fact, had recently completed a study that indicated the need for an EAP. Consequently, Babcock & Wilcox agreed to participate in the project.

The initial contract was with Babcock & Wilcox, but the full intent was to provide affordable EAP services to other community employers. Participating employers include public and private work organizations, ranging in size from as large as 3,600 workers to as small as 4 employees. All participating companies pay $15.50 annually for each employee, with a minimum fee of $500 per business. Larger businesses thus subsidize smaller companies to a certain extent; however, all companies seem satisfied with the fee structure, and larger participants report they are pleased to be "good neighbors" to the smaller employers.

EACV's board of directors is composed of chief executive officers or other senior executives from the various participating work organizations. This board of directors not only gives EACV outstanding leadership, but also enhances its reputation and credibility in the community. Companies interested in joining EACV must be approved by the board. In addition to the board, an advisory committee of human resources directors provides operational guidance.

EACV is a traditional assessment and referral EAP. Services are offered to employees and their family members. EACV is independent of any financial arrangements with the treatment community, and it negotiates with treatment providers for the best quality of services at the lowest cost. In fact, EACV offices are kept physically distant from any treatment providers to emphasize its independence from them. Supervisory training and consultation is an important part of EACV services, as are seminars on topical issues, such as workplace stress. On average, 8 to 11 percent of the work force from the participating companies utilize EACV services each year.

Creative responses like the EACV program are becoming more common in the business community. Smaller public employers are also looking at such nontraditional models for providing good workplace substance abuse programming, despite limited financial and personnel resources.

Cost sharing, in the end, is only one aspect of these programs, although it is an important one; sharing information, vision, and commitment is equally significant. Small and larger businesses working together to provide workplace alcohol and drug abuse programming may significantly enhance the effectiveness of these programs.

Workplace Resources

CSAP's National Workplace Helpline 1-800-WORKPLACE

Available from 9:00 a.m. to 8:00 p.m. (Eastern time), Monday through Friday, or by Internet e-mail at workhelp@samhsa.gov, CSAP's toll-free workplace helpline offers individualized technical assistance to business, industry, unions, and community-based organizations on the development and implementation of comprehensive alcohol- and drug-free workplace programs. Workplace specialists provide telephone consultation, resource referrals, networking services, and publications to assist in planning, policy development, and program implementation. Assistance is tailored to each organization's needs and characteristics, including contact information for locally available resources.

Publications

The following publications are available at no cost from the National Clearinghouse for Alcohol and Drug Information (NCADI). To order, call 1-800-729-6686.

"Making Your Workplace Drug-Free: A Kit for Employers (WORKIT)." Rockville, Md.: Center for Substance Abuse Prevention, 1995.

> This kit provides information, strategies, and easy-to-follow steps for implementing a drug-free workplace program or enhancing an existing one. While appropriate for employers of all sizes and types, the kit's simple, low-cost approach is particularly suitable for small businesses. It is based on the recommendations of business owners who have established, or want to establish, successful workplace substance abuse prevention initiatives. The materials, which are designed to be photocopied and distributed, target three workplace groups: employers, employees, and supervisors.

"Creating a Drug-Free Workplace: When the Issue Is Safety" and "Creating a Drug-Free Workplace: When Service Is Your Business." Rockville, Md.: Center for Substance Abuse Prevention, Spring 1996.

> These booklets describe basic low-cost steps small business owners and other employers can take to help their workers and improve profitability. They are included with the above WORKIT.

Cost-Effectiveness and Preventive Implications of Employee Assistance Programs. (SMA 95-3053). Rockville, Md.: Center for Substance Abuse Prevention, 1995.

CSAP Workplace HIV/AIDS Policy and Planning Guide: Lessons Learned From Workplace Substance Abuse Programs. (SMA 94-2083). Rockville, Md.: Center for Substance Abuse Prevention, 1994.

> This guide is designed to help employers respond to employees who are coping with HIV/AIDS or caring for someone with AIDS.

Videos

NCADI offers videos that address a variety of workplace substance abuse issues. They are available for a nominal fee. For a complete listing or to order a video, call NCADI at 1-800-729-6686.

NCADI's video selections include

"America in Jeopardy: The Young Employee and Drugs in the Workplace" (VHS44). Department of Labor, 1992.

"Drugs at Work" (employee and employer versions) (VHS01 and VHS02). NIDA, 1988.

"Getting Help" (employee and employer versions) (VHS03 and VHS04). NIDA, 1988.

"Drug Testing: Handle with Care" (employee and employer versions) (VHS05 and VHS06). NIDA, 1989.

"Finding Solutions" (VHS07). NIDA, 1989.

"Prevention Works. How to Make It Work in Your Community." CSAP, 1995 (includes segments on workplace).

Online Resources

PREVLINE provides public access to a wide range of resources from CSAP's National Clearinghouse for Alcohol and Drug Information (NCADI). PREVLINE (prevention online) is an electronic communication system, including downloadable files, dedicated to exchanging information concerning alcohol, tobacco, and drug abuse prevention. It is accessible with a computer and modem by dialing 301-770-0850, settings of N-8-1 and up to 14400 baud. It is also accessible via the World Wide Web at www.health.org, gopher at gopher.health.org, telnet at ncadi.health.org, and ftp at ftp.health.org.

EAP List—The Employee Assistance Internet Discussion List is a free networking tool for those interested in any aspect of employee assistance services and related workplace issues. List members include individual EAP providers, professional associations, managed care companies, corporations, university faculty, and students. Information found on the EAP List includes book reviews, topical discussions, calls for papers, conference announcements, job postings, and exchanges of training ideas and materials. To subscribe, send an Internet e-mail message to ea-request@eap.com. In the body of your message, type in SUBSCRIBE ea. It is also accessible via the World Wide Web at http://www.webcom.com/eap/ and ftp at ftp.webcom.com/pub1/eap.

Put Prevention Into Practice (PPIP) is a national preventive services campaign to increase the awareness and use of clinical preventive services by providers, patients, and office staff. PPIP is sponsored by the U.S. Public Health Service in cooperation with a dozen national health-related organizations. The campaign encourages consumers to work with their health care providers to stay well; organizations (health care systems, professional associations) to implement PPIP programs; educators to use PPIP materials in health professions curricula; and researchers to use PPIP research design tools. Resources on the Web page include a PPIP FAQ (frequently asked questions), a link to the National Health Information Center, and PPIP contact/ordering information (e-mail, phone, fax, mail). It is accessible via the World Wide Web at http://www.os.dhhs.gov:81/PPIP/.

Organizations

Employee Assistance Professionals Association (EAPA)
2101 Wilson Boulevard, Suite 500
Arlington, VA 22201-3062
703-522-6272

With more than 90 chapters throughout the United States, the EAPA is the largest national association of employee assistance program providers. In addition to its monthly publication, "EAPA Exchange," the association publishes brochures and booklets on a wide range of workplace issues.

Employee Assistance Society of North America (EASNA)
2728 Phillips
Berkley, MI 48072
810-545-3888

This large professional association of employee assistance program providers is composed almost equally of Canadian and American members. EASNA maintains the only EAP accreditation program that includes a managed behavioral health care component. The association also publishes "The Source," a quarterly newsletter.

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